Kathy R.:
A Resident at Kids Behavioral Health

An Investigative Report

by the
MONTANA ADVOCACY PROGRAM

September 29, 2005

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PREFACE

The Montana Advocacy Program ("MAP") is the designated protection and advocacy system for people with disabilities in Montana. One of MAP's functions is to advocate for people with disabilities who reside in institutions and investigate allegations of abuse and neglect. In early April of this year, MAP learned of an assault of a female youth resident at Kids Behavioral Health ("KBH") of Montana. This facility is an 85-bed residential treatment facility that provides psychiatric services to children and adolescents.

During MAP's investigation of this assault, MAP learned of various institutional problems that are the subject of the following report. MAP concludes that because KBH did not increase staff numbers to adequately monitor and treat recently admitted youth with aggressive behaviors, it was impossible for staff to protect Kathy R. from a series of well orchestrated assaults by a group of other residents that evening. It also led to an atmosphere where both youth and staff are not safe from physical harm. This environment has also led to the inappropriate restraint and seclusion of many youth.

On September 2, 2005, the Department of Public Health and Human Services, Quality Assurance Licensure Bureau issued an emergency order to KBH in the form of a Report of Licencing Deficiencies and Plan of Correction. Among other things, the report identifies the dramatically increased rate of assaults and use of emergency medication and physical restraint over the past year, as staff identified that they are unable to use less restrictive "de-escalation" techniques with the youth. The failure to use less restrictive de-escalation techniques is very troubling as restraint is a high risk intervention that is dangerous to both the resident and to the staff member. These risks "include serious injury or death, re-traumatization of people who have a history of trauma, and loss of dignity and other psychological harm." *National Association of State Mental Health Program Directors, Position Statement on Restraint and Seclusion*, July 13, 1999; *See also* GAO/HEHS-99-176, Use of Restraints, 3 (finding that children are at greater risk of injury than adults when restraint is employed).

The State's order prohibits the facility from admitting any more youth and requires the facility to hire additional staff, report all aggressive behavior, and correct all violations by October 3, 2005. The Report of Licencing Deficiencies was a result of the Quality Assurance Division's licensing investigation into a complaint from MAP in May 2005. It is provided in the Appendix to this report.

On September 8, 2005, MAP provided a draft of its report to the Administration of KBH, the Mental Health Board of Visitors, and DPHHS Quality Assurance

Licensure Bureau for comment. The responses we received are provided in the Appendix.

The response provided by KBH addresses only the recommendations provided within MAP's report and with the exception of a minor, but significant difference in the interpretation of materials from David Mandt and Associates regarding the appropriate duration of restraints, it does not take issue with the facts, analysis, or our conclusions. In most circumstances, KBH has adopted policies that address each of the recommendations MAP made. KBH provided those policies with its response, some of which were newly adopted and newly amended. In addition, KBH hired more staff prior to the issuance of MAP's report.

KBH's actions demonstrate some effort on the part of the facility to address the issues raised. However, MAP does not believe that these actions have adequately addressed the issues discussed in the MAP report or the issues identified by the Quality Assurance Licensure Bureau.

On September 29, 2005, MAP provided information to the Bureau in support of our conclusion that KBH's responses are inadequate. That information includes several allegations of recent aggressive and abusive incidents, three of which are allegations of staff abuse of youth, that KBH did not report to the state in violation of state and federal law.

Our primary motivation throughout the investigation and drafting of this report has been the well-being and safety of all of the youth who are in the facility. All of the youth at the facility are entitled to appropriate mental health care. The state's emergency order validated many of the reports of disturbing conditions and practices we uncovered in our investigation and we are not, at this time, convinced that the situation has improved.

Kathy R. and all of the other names included in the report are fictitious and specific information about the injuries sustained by Kathy R. or any other resident have been excluded out of concern for their medical privacy.

Sincerely,

MONTANA ADVOCACY PROGRAM

Bernadette Franks-Ongoy
Executive Director

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INTRODUCTION

On April 13, 2005, the Montana Advocacy Program (MAP), the designated protection and advocacy system for the state of Montana, received an Incident Report from Kids Behavioral Health (KBH), a psychiatric residential treatment facility for youth in Butte, Montana, indicating that two female residents assaulted and injured another resident, Kathy R., while she was sitting in a lounge at the facility on the evening of April 9, 2005. As Kathy R. had contacted MAP earlier in the year and reported that not only had she been threatened by other residents and was afraid for her own safety, but other residents and staff had been injured by residents, MAP immediately began an investigation

Although MAP's investigation was initially focused on the reported assault, MAP soon discovered that an investigation of that assault alone would not sufficiently explore the many issues regarding the management of the Girls' Gold Unit of KBH that contributed not only to a series of assaults against Kathy R. on April 9, 2005, but to an environment where many residents and staff do not feel safe. Accordingly, the following is a report regarding not just the reported assault on April 9, 2005, but many other serious issues regarding the management of the facility, including the adequacy of the current staff levels, the training of the staff, the aggressive behaviors of a significant portion of the residents, and the effects of these factors on the facility's compliance with federal and state law regarding safety, seclusion and restraint.

SUMMARY OF CONCLUSIONS

As a result of our investigation MAP found:

1. Various factors including the staffing pattern and the type of behavior of residents recently admitted and residing on Girl's Gold Unit at KBH have led to an atmosphere where both residents and staff are not safe from physical harm;

2. These same factors caused the staff to fail to effectively act to protect Kathy R. from assaults throughout the day and night of April 9, 2005;

3. Although the assaults of Kathy R. fit the definition of abuse under state law, KBH neither identified these incidents on April 9, 2005, as abuse, nor reported them as abuse;

4. KBH management's decision to provide insufficient staff to adequately address the aggressive behaviors of some of the residents admitted constitutes "failure to exercise supervisory responsibilities to protect patients from abuse" and is neglect under state law;

5. The assault of Kathy R. in the lounge on April 9, 2005, and resulting injuries qualify it as a "serious occurrence" under federal law and KBH policy;

6. The "Loss of Opportunity" or ("LOO") policy in place at the time of the April 9, 2005, incident is written so broadly and vaguely that staff interpreted it in a way that violated federal law; and

7. The appropriate restraint procedure is not followed in every instance and post-intervention debriefings are not being held after every intervention as required by the applicable federal law and KBH policy entitled "Seclusion and Restraint."

LEGAL FRAMEWORK

Kids Behavioral Health is a psychiatric residential treatment facility ("PRTF") under federal law. 42 C.F.R. § 483.352. For the purposes of this report, the relevant federal regulations applicable to PRTF's are as follows:

Reporting of Serious Incidents

Federal law requires that psychiatric residential treatment facilities must report every "serious occurrence." 42 C.F.R. § 483.374. The regulations provide that a serious occurrence includes situations when there is "serious injury" to a resident. Id. The regulations further define "serious injury" expansively and it includes "any significant impairment of the physical condition of the resident as determined by qualified medical personnel" which "includes but is not limited to burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else." 42 C.F.R. § 483.352.

Seclusion

"Seclusion" is "the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving." 42 C.F.R. § 483.352.

Seclusion can only occur pursuant to a physician or other licensed practitioner's order. 42 C.F.R. § 483.358. The resident is subject to monitoring throughout and debriefings are required which are more fully described in the following section. 42 C.F.R. § 483.364, 483.370. Seclusion cannot occur for longer than two hours for youth from age 9 to 17. 42 C.F.R. § 483.358 (e)(2).

Debriefings after Restraint or Seclusion

Within 24 hours after the use of restraint or seclusion, all staff involved in the intervention must have a "face-to-face discussion" with the resident. 42 C.F.R. § 483.370(a). The only exception to full staff participation is when the presence of a particular staff person at the debriefing may "jeopardize the well-being of the resident." Id. If appropriate, other staff members and the resident's parent(s) or legal guardian(s) may participate. Id. This discussion must provide an opportunity for all involved to talk about the circumstances that led to the restraint or seclusion, and the strategies that could have been used to prevent such an intervention in the future. Id. The staff must use language that the resident and the residents parent or guardian can understand.

Also within 24 hours, the staff involved in the intervention as well as supervisory and administrative staff must also conduct a debriefing session that includes at least a review and discussion of:

(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;

(2) Alternative techniques that might have prevented the use of the restraint or seclusion;

(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

42 C.F.R. § 483.370(b).

The fact that the debriefing sessions took place must be documented in the resident's record. This must include a list of all staff present at the debriefing, all staff excused from the debriefing, and any changes to the resident's treatment plan that occurred as a result of the debriefings. 42 U.S.C. § 483.370(c).

The relevant Montana law is:

Abuse and Neglect

KBH is a mental health facility pursuant to state law. Mont. Code Ann. § 53-21-102(10) (2003). State law prohibits "any form" of abuse or neglect of a person admitted to the facility. Mont. Code Ann. § 53-21-107(1) (2003).

"Abuse" in the context of mental health facilities is defined as "any willful, negligent or reckless mental, physical, sexual or verbal mistreatment or maltreatment or misappropriation of personal property of any person receiving treatment in a mental health facility that insults the psychosocial, physical or sexual integrity of any person receiving treatment in a mental health facility." Mont. Code Ann. § 53-21-102(1) (2003). This definition does not limit abuse to situations where staff have acted against a resident, but includes all such actions against residents, regardless of the aggressor.

"Neglect" includes the "failure to report abuse, or failure to exercise supervisory responsibilities to protect patients from abuse and neglect." Mont. Code Ann. § 53-21-102 (12)(a) (2003).

The relevant KBH polices are:
KBH policy requires "line of sight" supervision at all times during waking hours. [Resident Monitoring Policy, 7/30/03.] Residents are prohibited from spending time in their bedrooms during the day unless an exception applies. Id. These exceptions allow a resident to spend no more than five minutes in the room to prepare for a meal, clean her room, or prepare for bed, allows a resident to stay in bed if they are sick, if the resident refuses to leave bed, or for nap time for younger residents, and provides for other exceptions if they are specially requested by a staff member and approved. Id. at section 3.

The seclusion and restraint policy mirrors that of the federal requirements of 42 C.F.R. § 483 noted above. [Seclusion and Restraint Policy, 4/27/05.] It also specifically requires annual staff training on the Mandt system. Id. at section XVI (B)(1). The policy requires that when a restraint is used, it must be discontinued "[a]s soon as the resident is calm and assessed as no longer a danger to him/herself or others . . . ." Id. at section IV.

Policies also specifically require an inquiry into past sexual abuse of the resident at admission. Id. at III(A)(4). However, the policies do not address whether this shall have an effect on the use of opposite gender staff in a personal or physical restraint of the resident.

FACTS

On January 20, 2005, an advocate from MAP interviewed Kathy R., a resident at Kids Behavioral Health (KBH) in Butte, Montana. She told the advocate that she did not feel safe at KBH because there were other female residents in her unit, called "Girl's Gold," who had threatened to injure her.

Kathy R. stated that although she had filed grievances and verbally complained to staff about her fears, she believed that the grievances and complaints had not been acted on. According to records of the Resident Advocate, the Advocate reviewed Kathy R.'s complaint on Dec. 3, 2004, and sent it to the lead staff person because the complaint was regarding a "programmatic" issue. Kathy R. told MAP that she received no written response to her complaint from the Resident Advocate or the lead staff person.

At that time, Kathy R. also told the MAP advocate that she knew of three other residents on the Girl's Gold Unit who feared for their safety after having been threatened by other residents. She was aware that other residents had also submitted grievances and had received no response. Finally, Kathy R. said that staff members had told her that they also feared those same residents because they had injured other staff as well as other residents. Staff members also told her that they were concerned that some of these same residents might cause them injury. MAP has independently confirmed that these other residents and staff had these concerns about their physical safety during that time period.

On the morning of April 9, 2005, there was a confrontation between Kathy R. and a female resident named Michelle T., who is one of the residents Kathy R. had said four months prior that she thought was planning to harm her. The confrontation was of such a nature that staff members on the day shift intervened to separate them. The fact that the confrontation occurred was not relayed to the incoming staff on the following shift, who, when they were interviewed, stated that they were unaware that these two residents had an incident during the earlier shift. Five female staff members were assigned to that unit that evening to supervise 30 residents.

Later that day, four female residents, including Michelle T., assaulted Kathy R. and another female resident, Maria O., in a series of aggressive incidents spanning roughly two hours. The events began when three female residents (Deirdre M., Michelle T., and Paula K.) began a food fight in the cafeteria during dinner and later tried to barricade the door in the Girl's Gold

Unit. They began kicking the exit doors and one of them, Deirdre M., was physically restrained by one male staff member who was called from a different unit to assist the unit staff. She was restrained at approximately 17:10 while another staff member, who is female, stood by and watched. The male staff kept Deirdre M. in a restraint on the floor for several minutes. Eventually, other staff members provided assistance. The restraint ended 24 minutes later at approximately 17:34.

While staff were distracted by the events in the cafeteria, Cindy K. and Michelle T. went to Kathy R.'s room. At 17:12, Cindy K. entered Kathy R.'s room and pushed her against the wall and punched her face. Kathy R. attempted to defend herself and Cindy K. punched her again. Staff then entered Kathy R.'s room and intervened. Cindy K. ran past staff and out of Kathy R.'s room and attempted to run through the doors to the nursing station located between the girls' and boys' units. Staff caught up with Cindy K. and escorted her out of the Girl's Gold Unit. In the confusion, Michelle T. entered Kathy R.'s room and punched Kathy R. Staff called to assist from another unit physically restrained Michelle T. in the hallway. She was held in that restraint until approximately 17:34, roughly 22 minutes, at which time she was required to leave the Girl's Gold Unit and go to an area near the nursing station to calm down. Five minutes later, Michelle T. independently re-entered the Girl's Gold Unit, where she boasted to other residents about punching Kathy R. She also planned further aggression against Kathy R. and another resident, Maria O. MAP has found no evidence that there was an attempt by staff either at the nursing station or on the Girl's Gold Unit to assess whether Michelle T. was ready to return to the Unit prior to her return.

At 18:35, Michelle T. and Julie P. attempted to aggress against Kathy R. and Maria O. in the lounge. Staff intervened; however, one staff member was injured when she slipped and fell while positioning herself between fighting residents and another was injured when she was elbowed in the chest while trying to separate residents. There were multiple punches thrown, and considerable shoving and positioning between staff and the residents. After the altercation, staff sent Michelle T. back to the nursing station where she had been sent an hour prior. Staff sent Julie P. to her room. Soon after, Julie P. left her room and met with resident Paula K. in the hallway and planned another aggression against Kathy R. and Maria O.

Following their meeting in the hallway, Paula K. and Julie P. went to Julie P.'s room. At 19:14 both residents emerged from Julie P.'s room and ran past staff into the lounge where Kathy R. and

Maria O. were watching a movie with other residents and staff. Paula K. and Julie P. then aggressed against Kathy R. and Maria O. in the lounge, which resulted in multiple contusions to Kathy R.'s face, arms and legs in addition to an injury to her arm. Eventually, staff were able to separate the residents and Paula K. and Julie P. left the lounge. There was much confusion and according to one staff member interviewed, in the aftermath "the entire team was terrified and crying" and "staff felt unsafe."

Kathy R. was taken to the local hospital emergency room where she was treated at 20:44. Maria O. was not taken to the emergency room, although she had been injured in the incidents that evening, and still had bumps on her head from the altercation when she was interviewed by a MAP investigator five days later on April 14, 2005.

After Kathy R. returned from the hospital, staff stood outside both her room and Maria O.'s room as the girls had told staff that they were afraid that the same residents would try again to hurt them. That evening, various residents told staff that the four girls who had aggressed against Kathy R. and Maria O. were going to try again to do so the following morning.

Four days later on April 13, 2005, Lana Schaffer, KBH Director of Nurses, sent an Incident Report to MAP, the Mental Disabilities Board of Visitors, and the DPHHS Licensing Bureau indicating only that two female peers aggressed against another resident, Kathy R., while she was sitting in the lounge the evening of April 9, 2005. It included a list of some of the multiple injuries that Kathy R. sustained during the incident. The next day, a MAP investigator visited KBH and interviewed Kathy R. and learned that there was more than one assault against Kathy R. on April 9, 2005.

MAP began an investigation of these incidents at that time. MAP gathered factual information from a review of a videotape from surveillance cameras at KBH and photographs taken at the facility; written statements of KBH staff and youth; and interviews conducted with five residents, five direct care staff and two collateral staff. MAP also reviewed relevant correspondence, KBH policies and incident reports, federal and state law, the Butte/Silver Bow Law Enforcement Case Report regarding the incident and the St. James Healthcare/Emergency Department Physician's Orders and Instructions for the treatment of Kathy R.

On April 19, 2005, MAP received a letter from the KBH Clinical Director providing additional information about the status of the resident aggressors on April 9, 2005. In his letter, the Clinical Director states that KBH was not required to report the incident on April 9, 2005, to MAP as it "did not fit the

definition of serious injury for mandatory reporting," but KBH did so as a "precautionary measure."

ANALYSIS

Safety of Residents and Staff

Over the several months prior to the April 9, 2005, incidents, both residents and staff had expressed concerns about their safety due to the behavior of some aggressive residents, including Michelle T. and Cindy K. One resident told a MAP investigator that both before and after April 9, 2005, roommates developed elaborate plans for defending each other against aggression because they do not believe that staff would do so. The majority of both youth and staff interviewed expressed the concern that KBH has been accepting youth that were beyond its capability to keep safe and treat in light of the training of the staff and the number of staff available during any given shift. Four of the youth interviewed said they believed that there should be more requirements for staff hiring, including physical size or strength to ensure that staff will be physically capable of conducting an intervention with strong youth.

Both residents and staff indicated they believe KBH should have higher standards for hiring direct care staff and some staff expressed concern that the current staff to resident ratio is not sufficient to treat the youth served at the facility. The majority of residents and staff interviewed stated that they were wary of some residents, including those who aggressed on April 9, 2005, and were afraid for their continued safety over an extended period of time. Some staff admitted that they limited their contact with some of these residents. Both staff and youth gave mixed responses to whether they thought it would improve treatment and safety to have male staff on the adolescent girl's unit.

From these interviews, it is apparent to MAP that both staff and residents are very concerned about being harmed by more aggressive residents and are not confident that there are effective policies, practices and procedures in place to ensure that all residents are safe. If these concerns are not addressed, KBH will not only fail to provide a therapeutic environment, it will be the source of even further damage to the vulnerable youth whom it is supposed to serve.

It is also apparent to MAP that these concerns have led to many different results that seriously undermine the treatment provided in the Girls' Gold Unit of KBH, including not only the lack of effectiveness of the monitoring of residents to prevent physical confrontation, but the lack of

appropriate procedures when physical restraints are employed and the manipulation of time out policies to provide *de facto* seclusion.

Injury of Kathy R.

Kathy R.'s concerns about her safety in late 2004 and early 2005 are well documented. She complained to staff on several occasions in late 2004 that she did not feel safe and that she believed that other residents in the Girl's Gold Unit wanted to harm her. She was upset because she did not believe that staff had addressed this with the residents who had threatened her or done anything else to address her concerns. Her grievances were not answered, nor has MAP discerned any record of actions taken to address her concerns.

On the morning of April 9, 2005, Kathy R. and Michelle T. had a confrontation. Although the animosity between the girls involved in the incident was evident to at least those staff members who intervened in the confrontation, this information was not provided to the next shift of staff. These same staff members reported that shift changes are often so busy that it is not possible to relate such information about the residents to the next shift. Staff missed a crucial opportunity to prepare for or prevent at least some of the multiple altercations that evening.

Staff again had clear notice of this animosity when first Cindy K. and then Michelle T. shoved and punched Kathy R. in her room. Staff addressed this by removing Cindy K. from the unit and requiring Michelle T. to sit at the nursing station. Unfortunately, however, even though Michelle T. had been required to go to the nursing station to calm down after assaulting another resident, she was allowed to leave only five minutes after arriving at the nursing station, without the benefit of any discussion or assessment with staff to determine whether she was ready to return. She was clearly not ready to return, as she bragged about the initial assault on returning to the unit and promptly began to plan another assault.

This pattern continued throughout the next two hours. Although with each incident staff intervened after the aggression had begun and separated the aggressors, they did not follow through to monitor or counsel the aggressors. Although Cindy K. was taken out of the unit and not allowed to return, Michelle T. returned to the Unit only minutes after she left, and then teamed up with Julie P. to attempt to assault Kathy R. again. When they did so, staff sent Michelle T. back to the nursing station where she had been before, but sent Julie P. to her room. Soon after Julie P. left her room, sought out Paula K. and planned another assault on Kathy R. as well as Maria O. This series of assaults only

ended when Kathy R. was finally taken to the hospital.

Many of these lapses and lost opportunities can be attributed to the staffing pattern that evening. There were only five direct care staff assigned to supervise 30 residents that evening and they were apparently unable to perform their duties without the assistance of male staff members who had to respond from an adjoining unit. Even with this support, staff was unable to address the fracas in the cafeteria while assuring supervision of the other residents, which allowed Cindy K. and Michelle T. to assault Kathy R. Nor was the staff able to monitor the aggressors after each assault that evening to prevent further incidents.

Sufficient staffing alone, however, may not explain the actions taken by staff that evening. During MAP's investigation, various staff members familiar with the aggressors of April 9, 2005, admitted that they were concerned that those residents could cause them harm and that they believed that some of the recent youth admitted have behaviors that the staff cannot adequately address. Some staff admitted that the concern for their safety led them to limit their exposure to these residents. Based on this information, MAP believes that this concern played a significant role in the actions of staff in the Girls Gold Unit, and may very well have played a part in the staff's actions on April 9, 2005, specifically.

As the staff to resident ratio and the failure to increase staff after admitting residents with aggressive behavior are responsibilities of KBH management, KBH management and KBH staff failed to protect Kathy R. from injury on April 9, 2005.

Abuse and Neglect Determination

The assaults and resulting injuries to Kathy R. on April 9, 2005 fall under the definition of "abuse" in state law, which is defined as "any willful, negligent or reckless mental, physical, sexual or verbal mistreatment or maltreatment or misappropriation of personal property of any person receiving treatment in a mental health facility that insults the psychosocial, physical or sexual integrity of any person receiving treatment in a mental health facility." Mont. Code Ann. § 53-21-102(1) (2003). This definition does not limit abuse to situations where staff have acted against a resident, but includes all such actions against residents, regardless of the aggressor. Thus this provision requires that "client on client" incidents, as they are often called, are to be reported as abuses to the various oversight agencies to review pursuant to Montana Code Annotated § 53-21-107 (2003).

KBH neither identified these incidents on April 9, 2005 as abuses, nor

reported them as such, although KBH did report the assault in the lounge to the Board of Visitors as well as DPHHS and MAP. It is not clear whether KBH followed the statutory requirements for reporting abuse. However, it is clear that the institution did not identify these incidents as abuses, and should amend its practices to report such incidents, as failure to report abuse allegations is neglect under Montana law. Mont. Code Ann. § 53-21-102 (12)(a) (2003).

Finally, the failure to "exercise supervisory responsibilities to protect patients from abuse" is also neglect under Montana Code Annotated § 53-21-102 (12)(a) (2003). As discussed in the preceding section, KBH management's failure to provide sufficient staff to adequately address the aggressive behaviors of some of the residents led to the failure to prevent Kathy R.'s injuries. Thus, KBH management neglected Kathy R.

The Definition of Serious Incident

KBH determined that the one incident on April 9, 2005 that it reported (the final altercation in the lounge) did not fit the definition for mandatory reporting. Federal law and KBH policy both establish this incident is a "serious occurrence" and is reportable as Kathy R. received a serious injury.

Federal law requires that psychiatric residential treatment facilities must report every "serious occurrence." 42 C.F.R. § 483.374. The regulations provide that a serious occurrence includes situations when there is "serious injury" to a resident. The regulations further define "serious injury" expansively and includes "any significant impairment of the physical condition of the resident as determined by qualified medical personnel" which "includes but is not limited to burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else." 42 C.F.R. § 483.352.

The injuries that Kathy R. received as a result of the altercations fit the definition of serious injury and qualify the event as a serious occurrence, which must be reported. The incident was also a serious occurrence pursuant to KBH policy as the policy mirrors that of the federal law.

De Facto Seclusion

During this investigation, MAP also determined that KBH had promulgated a policy called "Loss of Opportunity" ("LOO") for use with youth with aggressive behaviors. We discovered that this policy is written in such vague terms that it has been used to put aggressive residents in long periods of *de facto* seclusion, keeping them isolated from other residents. Not only does the use of such a policy violate federal law, it is not an effective way to

address the institutional problems that KBH has apparently created by failing to staff according to the needs of the youth with aggressive behaviors who have been admitted.

Cindy K., the first resident to assault Kathy R. on April 9, 2005, was subject to the LOO policy for a prolonged period immediately after this incident. A review of this policy reveals that it does not contain specific or explicit direction as to the duration or the parameters of the policy. Perhaps most important, it does not provide whether a resident subject to the policy can be required to stay in her room by being physically prevented from leaving. This policy differs markedly from the "Assault Precautions" policy, which provides additional supervision of residents who are believed to be at risk of harming others, but does not isolate and seclude residents in a manner apparently authorized by the LOO policy. Copies of both policies are attached to this report.

Apparently pursuant to the policy, Cindy K. was required to stay in her room by herself for long periods of time during the day. When staff were interviewed, some believed that if Cindy K. attempted to leave her room, that they should physically prevent her from doing so. During the MAP investigation, a MAP advocate was led to Cindy K.'s room. At that time, Cindy K. had been subject to the LOO policy for more than two weeks. Cindy K. stated that she believed that she would be physically prevented from leaving, so she had not attempted to do so throughout that time.

Federal regulations governing PRTF's define "seclusion" as "the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving." 42 C.F.R. § 483.352. An institution may only seclude a resident pursuant to the order of a medical professional. 42 C.F.R. § 483.358. The resident must be monitored throughout the seclusion, and two different debriefings regarding the circumstances that led to the seclusion must occur. 42 C.F.R. §§ 483.364, 483.370. However, more important, seclusion cannot occur for longer than two hours if the youth is between the ages of 9 and 17. 42 C.F.R. § 483.358(e)(2).

This policy was used to seclude Cindy K. for long periods of time over more than two weeks without the benefit of any of the requirements provided by the federal regulations. As this was not a clear violation of the LOO policy, the LOO policy is seriously flawed and allows residents to be secluded for periods of time far greater than those allowed by federal law, without any of the protections required.

This is an inappropriate way to address the aggressive behaviors of some of the residents, as it results in long term

seclusion without precautions, and does not result in treatment for the residents. The LOO policy and all other similar policies that allow *de facto* seclusion in this manner must be discontinued.

Restraint

The restraints of both Michelle T. and Deirdre M. highlight another of the results of KBH's decision to admit youth with aggressive behaviors without providing adequate staff. This is the reliance of Girls' Gold Unit staff on male staff from another unit to restrain aggressive residents.

The videotape of the restraint of Deirdre M. on the evening of April 9, 2005, demonstrates this well. Staff from the Girls' Gold Unit apparently called another unit for help with the restraint. When a male staff member from another unit restrained Deirdre M., a female staff member from the Girls Gold Unit stood by and watched the restraint, although it is apparent from the videotape that the male staff member needed assistance. Eventually, another female staff member did assist.

From interviews with residents and staff, it is clear that many adolescent female residents feel uncomfortable being restrained by a man. Some stated that they believe they are often held inappropriately by male staff during physical restraint. Four of the youth interviewed expressed feeling very uncomfortable on one or more occasions with the way they were restrained. Their complaints were related to three different male staff. One youth specified that her blouse had "come up" and she felt exposed. When she asked that the blouse be pulled down, her request was ignored. The other complaints were that the staff were not doing the procedure correctly. The female youth especially objected to male staff doing a one-to-one restraint with them.

KBH policy provides that when a resident is first admitted, the facility must conduct an assessment which includes a determination of past sexual or physical abuse of the resident. This information is gathered to help plan the resident's care, and identify factors that would place a resident at greater risk during a restraint or seclusion. Seclusion and Restraint Policy, III(A)(4). However, the system wherein female staff from Girls' Gold Unit have to recruit male staff to conduct physical restraint makes it very difficult to limit opposite gender restraint in circumstances where the resident has a history of sexual abuse.

The restraints of Deirdre M. and Michelle T. raise other issues as well. Perhaps the most troubling issue regards the duration of the restraints. Each girl was restrained for at least 20 minutes on the floor that evening. Such a lengthy floor restraint is

contrary to the intentions of the Mandt System, which is the required training for staff pursuant to KBH policy. [Seclusion and Restraint Policy, 4/27/05 at section XVI (B)(1)]. According to the "Best Practices" statement provided on the Mandt System website, as restraint can cause trauma, serious injury or even death, it may be used only until the need for protection of serious harm to self or others is over, and in any case, may last for no longer than five minutes. http://www.mandtsystem.com. The restraints at issue lasted at least four times as long as the maximum time allowed according to the creators of the Mandt System. Not only did the staff conduct restraints in violation of Mandt in these instances, the gross nature of the violation raises serious concerns about the staff's compliance with the Mandt System generally.

Although it may be that the lack of sufficient staff training in the Mandt System is the explanation for these violations, KBH policy itself may also have contributed. KBH policy apparently authorizes the use of restraints for far longer than five minutes, as it not only provides no time limitation for restraints, it requires that the staff discontinue the restraint "[a]s soon as the resident is calm **and** assessed as no longer a danger to him/herself or others . . . " [Seclusion and Restraint Policy, 4/27/05 at section IV (emphasis added)]. Mandt best practices require that restraint is only used to protect people from seriously harming themselves or others and must be discontinued as soon as that threat is over. However, the KBH policy requires staff to continue the restraint even when a resident is no longer a danger to self or others if that resident is not "calm." This can, as it did in these cases, lead to restraints which last longer than a period recommended by the Mandt system. This requirement needlessly prolongs restraint and its potentially traumatizing effects and forces staff to act in a manner contrary to their Mandt training.

Queries with staff about the need for more staff training on physical restraint brought varied responses. Two staff said the training received once a year is adequate. Two other staff believed that more staff training is needed. Some believe that the best training comes from experience and not a classroom setting. Two staff also expressed concern that KBH is moving too quickly to eliminate the use of seclusion. Staff see conflicting messages coming from the administrators. The seclusion and restraint options for treatment are being removed at the same time the program is accepting youth for treatment who are more hostile and aggressive. The result is more injuries to both staff and residents, according to the staff members interviewed.

The final issue is the compliance with federal law and KBH policy requiring

post-intervention debriefings. See 42 C.F.R. §§483.370(a), (b), (c), provided above, see also Seclusion and Restraint Policy, at section XI, XII. During MAP's investigation, five KBH staff members were asked about their procedure regarding post-intervention debriefings following the restraint of a resident. Staff said that sometimes they are too busy for either a debriefing with the resident, or a staff debriefing. Most of the staff interviewed estimated that both of these sorts of debriefings occur only some of the time and often do not occur within 24 hours. Only one staff member interviewed estimated that the debriefings with residents occurred more often, and estimated that they occurred only 75 % of the time. Only one of the five youth interviewed told MAP that she has regularly met with staff following restraint interventions. The other youth interviewed said they "seldom" or "never" have met with all of the staff involved in the intervention within 24 hours following the procedure as required by federal CMS regulations.

Some staff said that resident staff debriefings are being done by the clinical director or the nurse, even though the clinical director or the nurse was not involved in the intervention.

Answers to questions about debriefing varied greatly, but it appears that not only is KBH failing to ensure that debriefings occur after restraints, but it has failed to ensure that staff members are aware of the requirements of federal law and KBH policy.

CONCLUSIONS

1. Staff and residents are very concerned about being harmed by more aggressive residents and are not confident that there are effective policies, practices and procedures in place to ensure that all residents are safe. These concerns have led to many different results that seriously undermine the treatment provided in the Girls' Gold Unit of KBH, including not only the lack of effectiveness of the monitoring of residents to prevent physical confrontation, but the lack of appropriate procedures when physical restraints are employed and the manipulation of time out policies to provide *de facto* seclusion.

2. Many if not all of the lapses on April 9, 2005, that led to Kathy R.'s injuries can be attributed in some manner to the staffing pattern that evening. Lack of sufficient staffing along with staff concerns that they may suffer injury from the resident aggressors contributed to the

failure to protect Kathy R. from injury. As the staff to resident ratio and the failure to increase staff after admitting residents with aggressive behavior are responsibilities of KBH management, KBH management and KBH staff failed to protect Kathy R. from injury on April 9, 2005.

3. The assaults of Kathy R. were abuse under state law. KBH neither identified these incidents on April 9, 2005, as abuses, nor reported them as such. KBH management's failure to provide sufficient staff to adequately address the aggressive behaviors of some of the residents led to the failure to prevent Kathy R.'s injuries and therefore KBH management neglected Kathy R..

4. Kathy R.'s injuries qualify the assaults against her as a serious occurrence, which must be reported pursuant to KBH policy and federal law.

5. The "Loss of Opportunity" ("LOO") is written in such vague terms that it has been used to put aggressive residents in long periods of *de facto* seclusion to keep isolated from other residents. Not only does the use of such a policy violate federal law, it is not an effective way to address the institutional problems that KBH has apparently created by failing to staff according to the needs of the youth with aggressive behaviors who have been admitted.

6. KBH has failed to ensure that debriefings occur after all restraints and has failed to sufficiently train staff regarding the requirements of federal law and KBH policy.

The restraints of both Michelle T. and Deirdre M. lasted four times longer than the maximum time period according to the creators of the Mandt System. This gross failure to follow the Mandt System in this case raises serious concerns about the staff's compliance with the Mandt System generally.

Male staff conducted restraints of adolescent girls on April 9, 2005. It appears that this is a common practice, and male staff are regularly recruited from other units to restrain adolescent girls. Many of the female residents interviewed by MAP feel uncomfortable when a male staff member restrains them. Although KBH policy requires a resident to be assessed for past sexual or physical abuse which will be taken into account to develop the resident's care plan, the current practice may make it very difficult to accommodate a resident with such a history.

RECOMMENDATIONS

MAP recommends that KBH take the following action:

1. Alter staffing patterns and increase the number of direct care staff sufficient to ensure the safety of both residents and staff;

2. Ensure that the consequences of unacceptable behavior are clearly communicated to both the youth and the staff and are uniformly applied;

3. Review the definitions of abuse and neglect under state law and comply with the reporting requirements;

4. Review the definition of serious occurrence within federal law and KBH policy and report incidents accordingly;

5. Discontinue the use of the "Loss of Opportunity" ("LOO") Policy and all similar policies;

6. Examine the current use of male staff to restrain adolescent girls in Girl's Gold Unit, and the coordination with the care plan for residents who have been subject to past sexual or physical abuse;

7. Provide more frequent and thorough staff training on the use of the Mandt system and monitor its implementation;

8. Amend the KBH policy entitled "Seclusion and Restraint" to comport with the Best Practices statement from Mandt and Associates and require that a restraint be discontinued as soon as a person is no longer a danger to self or others, and provide that a restraint may not exceed five minutes and eliminate the current requirement that resident be "calm" prior to the discontinuation of the restraint;

9. Ensure that debriefings are held following an emergency intervention by initiating an assessment of the capabilities of each staff involved in the emergency intervention to determine whether additional training for staff is needed, and, if training is needed, provide it; and

10. Review and amend assessment of serious incidents for purposes of reporting.

Attachments

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: **Special Program: Self-Focus/Loss of Opportunity**		**PAGE 1 of 2**	
FUNCTIONAL AREA: **Provision of Care, Treatment and Services**		**REFERENCES:** **PC 4.20**	
EFFECTIVE DATE: 10/23/01		**APPROVED BY: Executive Committee, MSEC, Governing Board**	
REVIEWED/REVISED: 11/20/02	REVIEWED/REVISED: 4/30/03	REVIEWED/REVISED: 12/29/04	REVIEWED/REVISED: 1/26/05

POLICY

Self-Focus/Loss of Opportunity (LOO) is a special program that is utilized with residents who are engaging in repetitive patters of behavior disruptive to the treatment milieu and/or their own progress. It is to be used as a temporary measure to have residents become redirected toward their treatment goals. It may be used with individual residents or with a resident team, as a group. To be able to return to normal milieu activities is the goal of Self-Focus/LOO.

PROCEDURE

The protocol is initiated after consultation with the Treatment Team (MD, Therapist, Nursing, MHAs, Program Lead). The need to continue the protocol will be evaluated by the Treatment Team daily. If individual residents are placed on Self-Focus/LOO and are thereby separated from their resident team, additional MHA staff may be required to supervise them.

1. Expectations of the Resident

   a. Follow expectations of the protocol.
   b. Work on assigned therapeutic assignments and/or assigned schoolwork.
   c. Initially, no interaction with peers. Peer interaction will be dependent on compliance with protocol and progress toward goals set for the Self Focus session.
   d. Minimal interaction with the MHA and nurse, as prescribed by the Treatment Team, if therapeutic assignments are done.
   e. One phone call is allowed on the regular phone call day. This call is to be with parent or guardian.
   f. Meals separate from other residents in the cafeteria, dayroom or other area as appropriate.
   g. Participation in physical exercise/activity at least one to two times daily
   h. May attend and participate in specific groups and activities at the discretion of the Program Lead.
   i. Process with the Therapist or psychiatrist daily.

2. Expectations for Nurse or Mental Health Associate

   a. Assist resident to learn and follow expectations of Special Focus protocol.
   b. Meet basic needs of resident while maintaining safety.
   c. Provide polite, limited interaction with the resident as specified by the Treatment Team; interactions focused on maintaining safety and encouraging resident to complete assignments.
   d. Be alert to resident attempts at manipulation to subvert the Self-Focus protocol into special time and attention that would be counter-therapeutically reinforcing.
   e. Document resident activity every 15 minutes on white check sheet.

3. Expectations for the Therapist

   a. Work with direct care staff to provide age/developmentally appropriate therapy Assignments.
   b. See the resident daily, providing an opportunity to review and process therapeutic assignments and set goals for Self-Focus time.
   c. Collaborate with the Treatment Team to assess the need to continue the Self–Focus Protocol.

4. Expectations for the Psychiatrist

   a. Participate with the Treatment Team in evaluating the need for Self-Focus/LOO protocol, in determining appropriate therapy assignments and goals for Self-Focus/LOO.
   b. Write/give time-limited orders to initiate, continue or discontinue the protocol as needed.

5. Transitioning back to the normal milieu activities

   a. The resident's cooperation and compliance in completing therapeutic assignments and identification and discussion of the behaviors that resulted in their being placed on Self-Focus/LOO will determine their readiness to begin participation in the regular program.
   b. Transitioning back to the normal milieu activities may begin when a resident, or the resident team as a group, shows evidence of being able to cooperate and comply in completing therapeutic assignments and school work, follow instructions, behave non-disruptively and express willingness to redirect themselves in a positive say towards their treatment goals. The transitioning process will include brief or time-limited periods of having the resident(s) reengage in normal milieu activities and alternate back to Self-Focus until the Treatment Team is convinced the resident(s) no longer need the stringent structure of Self-Focus/LOO.

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: ASSAULT PRECAUTIONS		**PAGE 1 of 3**	
FUNCTIONAL AREA: CARE OF RESIDENTS		**REFERENCES: TX 1.19**	
EFFECTIVE DATE: 1/28/99		**APPROVED BY: EXECUTIVE COMMITTEE, MSEC, GOV. BOARD**	
REVIEWED/REVISED: 9/7/00	**REVIEWED/REVISED:** 4/17/02	**REVIEWED/REVISED:** 05/22/02	**REVIEWED/REVISED:** 11/20/02

PURPOSE:

It is the policy of Kids Behavioral Health of Montana, Inc. (KBH) to protect residents from assaultive behaviors. Assaultive precautions are defined as specific nursing actions performed by the resident care staff to prevent a resident or residents from harming others.

PROCEDURE:

1. At the beginning of each shift, after the oncoming staff receives report, the Nursing Supervisor/Charge Nurse makes assignment on the mapping form for each team. Assignments should include consideration of each resident/residents needs and the abilities of the staff. Assignments include documentation of each of the following on the mapping form:

    a. Each resident/residents on assault precautions should have a specific staff assigned to their care for the entire shift, which is designated on the staff determination and mapping form.
    b. Each staff assigned a resident on precautions shall carry the clipboard for that resident the entire shift.
    c. Maximum number of residents on precautions should not exceed 5:1/five (5) resident/residents per one (1) staff.

2. The need for precautions to be reordered will be evaluated every 72 hours by the physician and written if indicated in the assessment of Nursing Personnel, if aggressive threatening behavior seems possible and no physician's order exists, assault precautions may be initiated temporally by Nurse Supervisor/Charge Nurse until the Psychiatrist can be reached for an order.

3. To ensure continuity of observation and care of residents on assault precautions, specific principles should be followed when a staff member is going on break, he/she gives the clipboard to the staff assigned as break coverage. The staff member is to go on break only if all of the following factors are present:

a. Staff assigned as break coverage is available for assault/precaution resident/residents.
b. The Nursing Supervisor/Charge Nurse has been informed that the staff will be leaving for break.
c. Clipboard for residents on assault precautions is current and physically handed over to break coverage staff.
d. Coverage staff has initialed the transition in the presence of the staff going on break.
e. The staff assigned as break coverage is not in charge of the rest of the team.

4. Specific documentation principles will apply:

a. The clipboard will be kept with staff at all times during the shift.
b. All entries on the boards will be made timely; actual time and entry are the same. It is not acceptable to make entries every two (2) hours, end of shift, etc.
c. A copy of the Assault Precaution Policy will be kept on each clipboard at all times.
d. Each resident on assault precautions should be on a separate board.
e. When completing the precaution checklists, each section of the sheet is detailed below:

1. Enter assault Precautions on top of the 15-minute check sheet. If the assault precautions are discontinued the Charge Nurse/ Nursing Supervisor informs the resident and staff and discontinues the precautions.
2. The staff assigned to the resident will enter his/her initials every 15 minutes and making a brief narrative under the comments section. Comments should include such tings as activity, peer interaction, aggressive behavior, verbal threats, mood and affect.
3. Any initials on the precaution sheet shall be entered at the bottom with the corresponding signature.
4. At the end of each shift, a charge nurse/nursing supervisor shall reassess each resident/residents on precautions. The charge nurse/nursing supervisor will evaluate the resident/residents mental status, degree of safety, etc., and make a judgment as to the value of continuing the current type of precaution and level. This information is entered under "Comment" on the therapeutic value of precautions every eight (8) hours.

f. There are specific issues that are imperative for successful precautions to be executed. These include, but are not limited to:

1. There are critical times during a shift that increased vigilance are necessary. These include staff breaks, resident bathroom time, showers, and bedtime and shift changes.
2. Conversations with family/significant others should be done while affording as much privacy as possible to the resident. After the conversation, assigned staff should evaluate the resident/residents

condition, noting any changes in behavior, mood, affect and interaction. Any details noted or contents of conversation should be communicated to the Nursing Supervisor/Charge Nurse. The Nursing Supervisor/Charge Nurse will disseminate this information to the receiving nurse at shift change and to the physician/therapist as necessary. An entry in the progress notes shall detail any of these specifics.

g. A resident/residents is placed on assaultive precautions by the attending psychiatrist when the danger of assaulting others is identified.
h. The 15-minute checklist is initiated and becomes a permanent part of the resident/residents record.
i. The resident is to be told the reason for being placed on precautions.
j. When precautions are ordered, all potentially harmful articles are removed from the resident/residents possession and room. These include:

    1. Pencils and pens.
    2. Notebooks with metal rings.
    3. Shampoos, soaps and other toiletries.
    4. Jewelry.
    5. Any other items that may be harmful or produce sharp edges.
    6. Any contraband as defined by Contraband Policy and Procedure.

k. In Adolescent Programs, a change of clothing search will be done every eight (8) hours; by two (2) same sex staff members. In Children's Programs, an initial "pat down" search will be done by (2) two same sex staff; any changes of clothing searches will be at the discretion of the Team Lead and Primary Therapist.
l. In Adolescent Programs, a room search will be done every eight (8) hours. In Children's Programs, room searches will be done at least once a day, during mid-day. The resident/residents will be present and will participate in the search, if willing, under supervision of staff.
m. Document in the reassessment note the status of the assaultive precautions, the resident's emotional response and affect and the value of continuing the precaution if indicated.
n. Residents are assigned 1:1 staff when specifically ordered by the physician, otherwise, resident is to be within arm's distance of staff AT ALL TIMES, when around other resident/residents. 1:1 staff is not required during sleeping hours, unless specifically ordered by a physician.
o. Staff members should use discretion as to whether or not to allow the resident/residents to have contact with other residents.
p. In Adolescent Programs, resident/residents are to eat meals at a separate table in the cafeteria and will be allowed a spoon only.
q. Assault Precautions are discontinued by physician order.

Appendix 1

Response from Office of the Governor Mental Disabilities Board of Visitors to MAP's Kathy R. Investigative Report

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS

RECEIVED
SEP 12 05
1:32P

BRIAN SCHWEITZER, GOVERNOR

PO BOX 200804

STATE OF MONTANA

(406) 444-3955
TOLL FREE 1-(800) 332-2272

HELENA, MONTANA 59620-0804
FAX: 406-444-3543

September 9, 2005

Bernadette Franks-Ongoy, Executive Director
Montana Advocacy Program
PO Box 1681
Helena, MT 59624

Dear Ms. Franks-Ongoy:

This letter is in response to your letter to me dated September 8, 2005 covering the Montana Advocacy Program (MAP) report entitled: JB: A Resident at Kids Behavioral Health / An Investigative Report. In your letter, you asked whether the Mental Disabilities Board of Visitors wished to "provide any information that may contradict the assertions or conclusions in the report."

BOV agrees with all of the assertions, conclusions, and recommendations in the report.

BOV has been corresponding with Charlie McCarthy of MAP and Beal Mossman of the Quality Assurance Division (QA) about our mutual concerns regarding the treatment environment of the residential treatment component of Kids Behavioral Health of Montana (KBH) for a number of weeks. As you may know, BOV conducted a site review of KBH on August 25 – 26, 2005.

BOV was so concerned with what it found that it: (1) sent a letter to KBH on September 1, 2005 invoking 53-21-104(7), MCA 2005, and (2) will be conducting a follow-up review on September 15 – 16, 2005, and another follow-up review focusing on KBH's use of medications on October 7, 2005. On September 1, 2005, the Director of QA, the Bureau Chief and Residential Program Manager of the Licensure Bureau, a Program Officer of the Children's Mental Health Bureau and I met to discuss our mutual concerns.

BOV will be producing a written report of its review of KBH. This report will contain recommendations that closely echo the recommendations in the MAP report, as well as additional recommendations.

Sincerely,

Gene Haire
Executive Director

Appendix 2

Response from Montana Department of Public Health and Human Services, Quality Assurance Licensure Bureau, to MAP's Kathy R. Investigative Report

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

JOAN MILES
DIRECTOR

STATE OF MONTANA

Phone: (406) 563-3448
Fax: (406) 563-7279

307 E. Park Avenue, Rm 305
Anaconda, MT 59711

September 20, 2005

Ms. Bernadette Franks-Ongoy
Montana Advocacy Program
PO Box 1681
Helena, MT 59624

RE: Investigation report/order

Dear Ms. Franks-Ongoy:

I have received a copy of your letter and report dated September 8, 2005 to Beal Mossman, QAD Surveyor. In response to your request I have enclosed a copy of the Report of Licensing Deficiencies and Plan of Correction submitted by Kids Behavioral Health of Montana. This report is the result of QAD's licensing investigation into the complaint made by MAP.

I have also enclosed a copy of the NOTICE OF VIOLATIONS AND ORDER the Department has issued against KBH. This action was taken in order to protect the residents at KBH.

Feel free to contact me if you have additional questions or concerns.

Sincerely,

Julie Fink
Residential Care Program Manager

CC: Charlie McCarthy; MAP
Beal Mossman, QAD

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

OF THE STATE OF MONTANA

In the Matter of:	)
	)
KIDS BEHAVIORAL HEALTH OF MONTANA,	)
55 Basin Creek Road	)
Butte, Montana 59701	)

NOTICE OF VIOLATIONS and ORDER

TO: Pam Broughton
Administrator
55 Basin Creek Road
Butte, Montana 59701

COMES NOW the Montana Department of Public Health and Human Services (Department), pursuant to Title 50, Chapter 5, Part 1 of the Montana Code Annotated (MCA), and hereby issues to Kids Behavioral Health of Montana (Kids), a residential treatment facility, by and through it's Administrator, Pam Broughton, the following Notice of Violations and Order to Cease New Admissions; Cease the Violations Within a Reasonable Time; and, to Increase Staff pursuant to Section 50-5-114 of the Montana Code Annotated (MCA).

The Department conducted a licensure survey at Kids on August 15-24, 2005. Department surveyors Julie Fink, Residential Care Program Manager; Beal Mossman, Mental Health Facility Surveyor; and, Bridget Parker, Community Residential Licensing Specialist reviewed and gathered the following documents: Kid's Daily Data Entry from August 2004 through July 2005; Kids' YDT FY Daily Entry form; and, the Kids' Incident Report from June 30, 2005 through July 31, 2005. Department Surveyors

interviewed 9 residents and 13 employees; reviewed 9 resident charts; inspected the facility; and reviewed Kids' Policy Manual.

The foregoing review of the incident reports revealed that from June 30, 2005, through July 31, 2005, there were 113 incidents of aggressive resident behavior. Of this number, 68 incidents involved resident on resident aggression; and, 45 incidents involved residents on staff aggression. The records revealed a total of 65 injuries as a result of resident aggression. The Kids' Staff are unable to protect the residents from assaults by peers due to inadequate staffing thereby putting both residents and staff in danger.

The situation at Kids has grown increasingly hazardous for residents and staff resulting in an escalation of injuries from August 2004 to July 2005. Resident injury due to peer aggression went from 9 injuries in August 2004, up to 54 in July 2005. Self-inflicted resident injuries were 15 in August 2004; and 31 in July 2005. Resident injuries from physical restraints were 6 in August 2004; and 20 in July 2005. Staff injuries due to resident aggression were 0 in August 2004, and 11 in July 2005. Staff injuries during restraint was 1 injury in August, 2004, and 36 in July, 2005. In summary, the total non-accidental injuries at Kids went from 31 injuries in August 2004, up to 152 in July 2005.

NOTICE OF VIOLATIONS

Violation #1: 37.106.2202(1)(a)(iv)(A) ARM; plant, technology and safety management (PL), as specified for residential settings in Appendix A of PL.1; and, Pl.1.1 of the Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities.

PL.1 A Safety management program exists that is designed to provide a hazard-free physical environment and to manage staff activities to reduce the risk of human injury. The safety management program does not manage staff activities to reduce the risk of human injury.

Pl.1 The governing body strives to assure a safe environment for patients, personnel, and visitors by requiring and supporting the establishment and maintenance of an effective safety management program.

The Governing Board of Kids Behavioral Health of Montana (Kids) has not strived to assure a safe environment for the residents and staff at Kids. The number of injuries to residents and staff has increased dramatically in the last year. Kids' daily data entry for August 2004 documents 31 non-accidental injuries to patients and staff. Over the past 12 months, the daily data entry for each month has steadily increased.

The most recent survey from August 15-24, 2005 revealed that Kids had 152 non-accidental injuries to patients and staff for July 2005. During this survey, staff members expressed concern for their own safety while at work. Staff reported incidents of residents physically assaulting staff. The survey also revealed that the resident to staff ratio was inadequate as staff are unable to control the resident's behaviors resulting in a dramatic increase in resident and staff injuries. Staff are unable to handle the resident's negative behavior and find that the work environment is in a continual state of one crisis after the next.

Staff reported they are not able to use less restrictive de-escalation techniques and have stated they are responding immediately with physical restraint followed by emergency medications such as benadryl and zyprexa. Since January 2005 the use of physical restraints and emergency medications has increased dramatically. In January 2005, Kids' staff used physical restraints 122 times. In July 2005, staff used physical restraint a total of 347 times. An increase in emergency medication use during this same period went from 53 in January, up to 147 in July.

Staff are frequently called off of their assigned units to assist in Emergency Safety Interventions which leaves one staff member alone with up to 14 residents. This puts staff and residents at great risk as the residents take advantage of the low staffing and assault other residents. Staff reported these concerns to Kids' Administrative Personnel however no change has occurred. For example, on July 26, 2005, a male resident was assaulted by a peer when staff were called to assist with a situation on the Gold Girls unit. The victim was sent to the emergency room with a fractured nose. There are many other examples of low staffing resulting in resident assaults and non-accidental injuries.

ORDER

Pursuant to Sections 50-5-114(1) and 2-4-631 MCA, the Department finds that public health, safety or welfare imperatively requires emergency action. Pending further proceedings, the Department Orders Kids Behavioral Health of Montana to comply with the following conditions:

A. The department places a moratorium on new admissions, effective immediately, until additional information becomes available and immediate corrective action has proven to be effective.

B. Immediately increase staffing to adequately meet the needs of the residents, supervise the residents, and prevent non-accidental injuries to residents and staff;

C. Kid's Behavioral Health of Montana will report any aggressive behavior by residents to the Department of Public Health and Human Services, Quality Assurance Licensure Bureau.

D. Correct all alleged violations by October 3, 2005.

NOTICE OF RIGHT TO ADMINISTRATIVE HEARING

Pursuant to §§ 50-5-114, MCA, Kids Behavioral Health of Montana is hereby given notice that it has a right to a hearing. The contested case provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, part 6, MCA, would apply. This Order becomes final unless, within 30 days after this Notice is received, Kids requests, in writing, a hearing before the department. A request for hearing must be addressed to:

Office of Fair Hearings
Montana Department of Public Health and Human Services
201 Colonial Drive
P.O. Box 202953
Helena, Montana 59620-2953

Until issuance of a contrary decision by the department, this Order remains effective and enforceable.

DATED this 2nd day of September, 2005.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

By: Mary E. Dalton
Mary Dalton, Administrator
Division of Quality Assurance

Statement of Deficiencies and Plan for Correction
Revised 8/26/05

Name of Facility: Kid's Behavioral Health of Montana Inc.

Address: 55 Basin Creek Road Butte, MT 59701 **Dates of Survey:** 5/31/05 and 6/1/05

- This response has been updated to include revised answers in bold where previous responses were not accepted
- If the answer previously stated "same as #..." or "see #... above", the written response is there in its place
- Page numbers may differ from the previous response and/or the 8/9/05 letter of Response Not Accepted

Deficiency	Plan of Correction	Completion Date
The following Administrative Rule is cited for each deficiency cited. For clarity the rule will not be repeated through out the Statement of Licensure Deficiencies. **37.106.330 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: WRITTEN POLICY AND PROCEDURE** (1) A written policy and procedure for all services provided in a health care facility must be available to and followed by all personnel. ********** **Kids Behavioral Health of Montana, Inc. Policy and Procedure: Special Program: Self Focus/Loss of Opportunity" "reviewed / revised 1/26/05"** *** Procedure — "If individual residents are placed on Self Focus/ LOO and are thereby separated from their resident team, additional staff may be required to supervise them." 1 Expectations of the Resident: *** c) initially, no interaction with peers d) minimal interactions with the MHA and nurse And; **"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Seclusion and Restraint" "reviewed / revised 4/27/05.** *** Procedure Policy Statement: Kids Behavioral Health (KBH) of Montana's primary focus is to protect the rights of residents and to insure that care and treatment are provided in a safe and secure setting. Therefore, restraint and seclusion are used only in an Emergency Safety Situation when there is an imminent risk of a resident physically harming him/herself or others, including staff members. I. Definitions: A. Drug used as Restraint: Any drug that is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others, has the temporary effect of restricting the resident's freedom of movement and is not a standard treatment for the resident's medical or psychiatric condition. *** G. Seclusion: The involuntary confinement of a resident alone in a room or an area from which the client is prevented from leaving. And; **Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical**		

Dependency, and Mental Retardation / Developmental Disabilities Services **PM.11 Progress notes are entered in the clinical record.** *** PM.11.2 All entries involving subjective interpretation of the patient's progress are supplemented with a description of the actual behavior observed. *** **SC.1 Designated special treatment procedures require clinical justification.** SC. 1. I Such treatment procedures include, but are not necessarily limited to the following: SC. 1. 1. 1 seclusion; SC.1.1.2 restraint *** SC.1.2 The rationale for using special treatment procedures is clearly stated in the clinical record of the individual served. *** **SC.2 The organization has written policies and procedures that govern the use of seclusion or restraint.** SC.2.1 Using seclusion or restraint requires clinical justification. SC.2-1.1 Seclusion or restraint is used only to prevent the individual served from injuring himself/herself or others or to prevent serious disruption of the therapeutic environment. SC.2.1.2 Seclusion or restraint is not used as punishment or for staff convenience. SC.2.1.3 The rationale for using seclusion or restraint addresses the inadequacy of less restrictive intervention techniques. *** SC.2.7 The head of the professional staff and/or a designee reviews daily all uses of seclusion or restraint and investigates unusual or possibly unwarranted use patterns. *** SC.2.9 Seclusion or restraint is not to be used in a manner that causes undue physical discomfort, harm, or pain to the individual served. **The intent of the rules is not met as evidenced by:** 1) Surveyor's review of resident #1's Chart. 2) Surveyor's 5/31/05 treatment team meeting with staff member # 1, staff member # 2 and staff member # 3. 3) Surveyor's review of the resident #1's "The Resident Locator Sheet" for April 2005 and May 2005. **Findings:** Resident was placed on Self Focus/Loss of Opportunity from 4/10/05 – 4/17/05 and 4/28/05 – 5/15/05. The resident was 1. involuntary confined alone in a room or an area from which the client is prevented from leaving. This is defined as "seclusion". The facility did not follow the seclusion regulations during this time as follows: a. The rational for using seclusion was not clearly stated in the residents record. b. Clinical justification for using seclusion was not clearly documented in resident's record. c. Seclusion was not used only to prevent the individual served from injuring himself/herself or others or to prevent serious disruption of the therapeutic environment. d. Seclusion was used as punishment or for staff convenience during this timeframe as in many cases	**It was not the intent of KIDS Behavioral Health of Montana to create a seclusion in its implementation of the previous Loss of Opportunity Policy and Procedure. Upon further review, KBH has discontinued the use of Loss of Opportunity and implemented its Special Intervention: Intensive Focus Policy and Procedure (attached) on 7/27/05. Nurses training occurred on 7/19/05 and all clinical staff received the policy and procedure on 7/22/05. Health Information Management will audit resident charts to ensure appropriate documentation is occurring specific to continued access to treatment, therapy and**	7/27/05

documentation does not exist that resident was a threat. e. Resident records did not include documentation of the rationale for using seclusion addressing the inadequacy of less restrictive intervention techniques. f. The head of the professional staff and/or a designee did not review daily all uses of seclusion and investigate unusual or possibly unwarranted use patterns.	education. If an Emergency Safety Situation or Emergency Safety Intervention (ESS/ESI) occurs while a resident is on Intensive Focus, KBH will follow our policy and procedure on seclusion and/or restraint.	
2. "Drugs used as restraint" were administered to resident on 28 occasions during 4/1/05 – 5/19/05. The facility did not follow restraint regulations as follows: a. Records do not reflect there was imminent risk of a resident physically harming him/herself or others, including staff members 20 out of the 28 occasions "drugs" were used as restraint. Staff did not document these incidents as being an "emergency safety situation". b. On 5/11/05 the resident was given "drugs used as restraint" when documentation clearly states there was not an imminent risk of the resident physically harming him/herself or others, including staff members. c. The rational for using "drugs as restraint" was not clearing stated in the residents record. d. Clinical justification for using "drugs as restraint" was not clearing documented in residents record. e. "Drugs used as restraint" was not used only to prevent the individual served from injuring himself/herself or others or to prevent serious disruption of the therapeutic environment. f. Restraint was used as punishment or for staff convenience during this timeframe as in many cases documentation does not exist that resident was a threat. g. Resident records did not include documentation of the rationale for using restraint or addressing the inadequacy of less restrictive intervention techniques. h. The head of the professional staff and/or a designee did not review daily all uses of restraint and investigate unusual or possibly unwarranted use patterns.	In order to conform with the guidelines required in this Statement of Deficiencies, KBH is implementing a new Emergency Medication Policy and Procedure (draft policy attached) and revising our existing Seclusion and Restraint Policy and Procedure to include emergency medications as an ESI (draft policy to be forwarded upon completion). Audit procedures will be performed by nursing staff and reviewed by the Director of Nursing (DON) to include debriefing, guardian contact and use of emergency medications. Our target date is 9/12/05 for revision of the Seclusion and Restraint Policy and Procedure and full implementation of the Emergency Medications Policy and Procedure.	9/12/05

Deficiency	Plan of Correction	Completion Date
Kids Behavioral Health of Montana, Inc. Policy and Procedure: Special Program: Self Focus/Loss of Opportunity" "reviewed / revised 1/26/05" *** Procedure The need to continue protocol will be evaluated by the Treatment Team daily. *** 2) Expectation for the Nurse or Mental Health Associate *** e) Document resident activity every 15 minutes on white check sheet. *** 3) Expectation for the Therapist b) See the resident daily, providing an opportunity to review and process therapeutic assignment and set goals for Self Focus time. c) Collaborate with the Treatment Team to assess the need to continue the Self Focus protocol. 4) Expectation for the Psychiatrist a) Participate with the Treatment Team in the evaluating the need for Self-Focus/LOO protocol, in determining appropriate therapy assignments and goals for Self-Focus/LOO.		

b) Write/give time-limited orders to initiate, continue or discontinue the protocol as needed. And; **Title 42 of the Code of Federal Regulations (CFR), part 441, subpart D (effective October 1, 1992), which contains standards for provision of inpatient psychiatric services to individuals under age 21.** " CFR42S94 441.154 Active treatment. Inpatient psychiatric services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care And; **The 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services, published by the Joint Commission on Accreditation of Healthcare Organizations** " SC.2.10 Appropriate attention is paid every 15 minutes to an individual in seclusion or restrains SC.2.10.1 Documentation in the clinical record of the individual served indicates that such attention was given " PI.2 The organization has a written plan or policies and procedures that describe the rights of patients and the means by which these rights are protected and exercised. PI.2.1.1 each patient has impartial access to treatment, regardless of race, religion, sex, ethnicity, age, or handicap: **The intent of the rules is not met as evidenced by:** 1) Surveyor's 5/31/05 treatment team meeting with staff member # 1, staff member # 2 and staff member # 3. 2) Surveyor's review of resident #1's Chart. **Findings:** 1) Resident was placed on LOO from 4/10/05 to 4/17/05 and 4/26/05 to 5/15/05. Resident records do not reflect that the need to continue protocol was evaluated daily by the treatment team. 2) There is no record on file that states staff documented residents activity every 15 minutes while on LOO. Staff stated during Treatment Team meeting that they did not complete the documentation every 15 minutes on white check sheet. 3) Records do not reflect that the resident was seen by a therapist daily for the following dates: 4/10/05, 4/13/05, 4/14/05, 4/15/05, 4/16/05, 4/26/05, 4/27/05 4/28/05, 4/29/05, 4/30/05, 4/31/05, 5/1/05, 5/2/05, 5/3/05, and 5/4/05. A therapist may have worked with resident #1 after 5/5/05, but there is no record in the "chart". 4) Resident records do no reflect that the therapist collaborated with the treatment team to assess the need to continue the Self Focus protocol. 5) Resident records do not reflect that the Psychiatrist participated with the treatment team in evaluating the need for LOO protocol, determining appropriate therapy assignments or goals for LOO. 6) There is no documentation in the residents record that reflect the Psychiatrists time-limited orders to initiate, continue or discontinue the protocol as needed.	We recognize that we did not, in all cases, follow all of the procedures outlined in our policy for LOO. We are currently in the process of formulating a revised policy for a Special Program to be called Intensive Focus (IF) rather than LOO to address our findings #1-7.	7/27/05 for revision of policy and report forms; 8/5/05 nurses, program leads and therapists will be trained; 8/6/05 implement changes

7) Based on the documentation above the resident was not involved in "active treatment" during days placed on LOO.		
8) Based on the information above the resident did not have impartial access to treatment during days placed on LOO.	**It was not the intent of KIDS Behavioral Health of Montana to create a seclusion in its implementation of the previous Loss of Opportunity Policy and Procedure. Upon further review, KBH has discontinued the use of Loss of Opportunity and implemented its Special Intervention: Intensive Focus Policy and Procedure (attached) on 7/27/05. Nurses training occurred on 7/19/05 and all clinical staff received the policy and procedure on 7/22/05. Health Information Management will audit resident charts to ensure appropriate documentation is occurring specific to continued access to treatment, therapy and education. If an Emergency Safety Situation or Emergency Safety Intervention (ESS/ESI) occurs while a resident is on Intensive Focus, KBH will follow our policy and procedure on seclusion and/or restraint.**	7/27/05
9) The facility did not provide an adequate number of competent, qualified, and experienced professional clinical staff to supervise and implement the treatment plan while resident was placed on LOO.	Appropriate staff were provided for the resident but documentation was incomplete. Steve Heinz, Clinical Director will develop an Intensive Focus Form to provide documentation of continuous justification for IF, the professional staff who saw the resident while on IF and the treatment provided to the resident.	8/5/05

Deficiency	Plan of Correction	Completion Date
"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Treatment Plan Policy—RTC" "reviewed / revised 12/29/04" *** 2. Master Treatment Plan and Reviews d. Treatment plan reviews occur: *** 2) Whenever a change in status occurs necessitating special interventions, e.g., increase in number of ESIs (a special staffing form may be utilized for this update). And; **"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Seclusion and Restraint" "reviewed / revised 4/27/05"** III Plan of Care C. The KBH Treatment Team will review each resident's admission information as to a history of aggressive impulses and behavior. When a resident has had occurrences of discrete episodes of failure to resist aggressive impulses that may result in serious assaultive acts toward self or others, the treatment team will identify this in the resident's Treatment Plan as a "Problem." Specified interventions and goals will be determined by the Treatment Team and addressed in the resident's Treatment Plan. The Treatment Plan may include the use of seclusion and/or restraint interventions. • A Treatment Plan for aggressive behaviors will also be developed by the Treatment Team for any resident who has had no previous pre-admission history of aggressive behaviors but who demonstrates aggression after admission that compromises the safety of the resident or others. ***		

XV. Notification of Clinical/Administrative Leadership of KBH *** C. When multiple or extended episodes of seclusion or restraint are identified for a resident, a Special Treatment Team Staffing is held and appropriate modifications and recommendations are made to the Treatment Plan. And; **Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation / Developmental Disabilities Services** CA.6 For each child and adolescent served, a written, comprehensive, and individualized treatment plan exits.*** CA.6.3 The treatment plan is periodically reviewed, based on an assessment of the current clinical problems, needs, and responses to treatment of the individuals served. CA.6.3.1 The review is conducted CA.6.3.1.1 when major clinical changes occur *** **PM.11 Progress notes are entered in the clinical record.** *** PM.11.2 All entries involving subjective interpretation of the patient's progress are supplemented with a description of the actual behavior observed. **The intent of the rules is not met as evidenced by:** 1) Surveyor's 5/31/05 treatment team meeting with staff member # 1, staff member # 2 and staff member # 3 2) Surveyor's review of resident #1's Chart. 2) "Kid's Behavioral Health of Montana Residential Treatment Center Psychiatric Evaluation" of 10/31/04 3) Surveyor's review of "Kid's Behavioral Health of Montana Master Treatment Plan of 11/11/04 **Findings:** 1. resident #1 was in the Loss of Opportunity Program (LOO) during her waking hours from 4/10/05 to 4/17/05, and from 4/26/05 to 5/17/05. "Treatment plan reviews" did not "occur whenever a change in status occurs necessitating special interventions". 2. "Serious assaultive acts" were not identified in the residents initial treatment plan as a "problem" even though assaultive acts were described in the "Psychiatric Evaluation". 3. Resident's initial treatment plan does not include specific interventions and goals for aggressive behavior. 4. In April 2005 resident #1's Chart records 16 incidents of restraint or seclusion. From May 1, 2005 to May 19, 2005 there were 28 incidents of restraint and seclusion. In April, 2005 there were 9 incidents of "drug used as restraint" for resident #1. From May 1, 2005 to May 19, 2005 there have been 19 incidents of "drug used as restraint" for resident #1. No Special Staffing treatment team staffing had occurred since 3/7/05 to address the multiple or extended episodes of restraint.	Documentation of evaluation for IF will be included in the treatment plan section of the medical records to be incorporated into the MTP at the next MTP review. **The Clinical Director will conduct training on 8/1/05 on the completion of the Initial Treatment Plan with nursing and therapy staff, listing appropriate goals, objectives and interventions specifically regarding aggressive and self harming behaviors. The Clinical Director will audit the Initial Treatment Plan and the Master Treatment Plan (MTP) to ensure goals, objectives and interventions are listed.**	7/13/05 for therapist training; 7/14/05 to implement 9/1/05

5. The treatment plan was not periodically reviewed, based on an assessment of the current clinical problems, needs, and responses to treatment of the individuals served. The use of an excessive number of restraints and seclusion was not addressed in current treatment plan. 6. When "seclusion" and "drugs used as restraint" were implemented following a "subjective interpretation of the patient's progress" by the staff, often this interpretation was not "supplemented" in the resident's chart "with a description of the actual behavior observed".	Excessive incidents of aggression were reported; however the treatment plan was not changed to reflect this. Steve Heinz, Clinical Director will conduct an inservice for therapists using this deficiency report as the basis for the training. Excessive incidents of aggression were reported; however the treatment plan was not changed to reflect this. Steve Heinz, Clinical Director will conduct an inservice for therapists using this deficiency report as the basis for the training.	7/13/05 for therapist inservice; 7/14/05 to implement 7/13/05 for therapist inservice; 7/14/05 to implement
Kids Behavioral Health of Montana, Inc. Policy and Procedure: Special Program: Self Focus/Loss of Opportunity" "reviewed / revised 1/26/05" *** Procedure — "If individual residents are placed on Self Focus/ LOO and are thereby separated from their resident team, additional staff may be required to supervise them." 1 Expectations of the Resident: *** c) initially, no interaction with peers And; **Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation / Developmental Disabilities Services** CA.3 When treatment separates the child or adolescent from normal or daily living experiences for a significant period of time, the needs of the individual serviced for the daily living activities are provided for in the physical and social environment. *** CA.3.2 Provisions are made in the social environment for *** CA.3.2.2. peer and group interaction*** CA.3.2.4 educational activities CA.3.3 Needed services are provided directly or through referral, consultation, or contractual arrangements and/or agreements *** **The intent of the rules is not met as evidenced by:** 1)Surveyor's review of resident #1's "Master Treatment Plan and Review /Update" of 3/30/05 and 4/26/05. 2) Surveyor's review of resident #1's "Kids Behavioral Health Weekly Education Notes" for April 2005 and May 2005. 3) Surveyor's review of the resident #1's "The Resident Locator Sheet" for April 2005 and May 2005. 4) Surveyor's review of resident #1's Chart.		

Findings: 1. Resident record does not have documentation of how the facility made provisions for peer and group interaction while placed on LOO. 2. Resident record does not have documentation of how the facility made provisions for educational services while placed on LOO. 3. Resident record does not have documentation of how needed services were provided while placed on LOO.	A procedure for documenting this will be defined in a revised policy for IF. Anne Dodge, Principal will train teachers on documenting educational assignments given to residents on IF. This will be done on the weekly education review form. A procedure for documenting this will be defined in a revised policy for IF.	8/5/05 8/5/05 8/5/05

Deficiency	Plan of Correction	Completion Date
"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Seclusion and Restraint" "reviewed / revised 4/27/05. **Seclusion and Restraint Policy Statement:** KIDS Behavioral Health (KBH) of Montana's primary focus is to protect the rights of residents and to insure that care and treatment are provided in a safe and secure setting. Therefore, restraint and seclusion are used only in an Emergency Safety Situation when there is an imminent risk of a resident physically harming him/herself or others, including staff members. " If a resident sustains an injury during a seclusion and/or restraint procedure, the resident will be immediately assessed by a nurse, and then further evaluated by the medical physician for assessment of "serious injury." In the absence of the medical physician, the Medical Director will assess the injuries of the resident and document her/his assessment in the resident's chart. VIII. Assessment and Documentation " B. Within 1 hour of the initiation of the Emergency Safety Intervention a physician, or other licensed practitioner" trained in the use of Emergency Safety Interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to: The resident's physical and psychological status. 2. The resident's behavior. 3. The appropriateness of the intervention measures. 4. Any complications resulting from the intervention. C. Staff must document the intervention in the resident's record. " 3. The time and results of the 1 hour assessment " XI. Post-Intervention Assessment A. Debriefing / 1 Within 24 hours after the use of restraint or seclusion, staff involved in an Emergency Safety Intervention and the resident must have a face-to-face discussion. And; **Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical**		

Dependency, and Mental Retardation / Developmental Disabilities Services **PM.11 Progress notes are entered in the clinical record.** *** PM.11.2 All entries involving subjective interpretation of the patient's progress are supplemented with a description of the actual behavior observed. SC.2.9 Seclusion or restraint is not used in a manner that causes undue physical discomfort, harm, or pain to the individual served. **The intent of the rules is not met as evidenced by:** Surveyor's review of resident #1's Chart. **Findings:** The 5/11/05 MHA progress note by Margie Main, Mental Health Associate (MHA) describes request for "restraint" of resident #1. The Progress note states, "Resident was up. Still on LOO. Walked out of her room and heading down hall. Staff prompted once and then called nurse. Resident did ask for blue room before all this started. Nurse came down and res went willingly with nurse up to nurse's station to get shoots. Tissue damage on one arm so had to use other. Resident in blue room for about 10 minutes then went back to room to sleep until about 11:00 AM." 1. The "rights of the resident" were violated because "drugs" were used as restraint by the staff without justification. 2. Neither the Mental Health Associate nor the nurses provide examples of behaviors or other specific evidence that indicate resident #1's was an "imminent risk — of physically harming — herself or others".	**In order to conform with the guidelines required in this Statement of Deficiencies we are implementing a new Emergency Medication Policy and Procedure (draft policy attached) and revising our existing Seclusion and Restraint Policy and Procedure to include emergency medications as an ESI (draft policy to be forwarded upon completion). Audit procedures will be performed by nursing staff and reviewed by the Director of Nursing (DON) to include debriefing, guardian contact and use of emergency medications. Our target date is 9/12/05 for revision of the Seclusion and Restraint Policy and Procedure and full implementation of the Emergency Medications Policy and Procedure.**	**9/12/05**
3. Resident was not assessed by a medical physician or by the director for injuries received during restraint procedures. These injuries were document above as well as 5/11/05 progress notes by staff stating, "patient received a IM and nurse used her buttocks for the shot due to her arm having so many needle marks from previous IMs that her arms were very sore. 4. Resident records do not reflect a face-to face assessment within 1 hour of the initiation of the Emergency Safety Intervention. 5. Review of residents "Emergency Safety Situation/Intervention Report Forms" dated 4/8/05 at 830 for physical restraint, 4/13/05 at 1800 for physical restraint, 4/13/05 at 1820 for seclusion, 4/16/05 at 1140 for physical restraint, 4/25/05 at 2030 for physical restraint, 5/11/05 at 805 for "drugs used as restraint", and 5/11/05 at 1530 for "drugs used as restraint" do not have "the time and results of the 1 hour assessment" documented "in the resident's record". 6. Resident records do not reflect a face-to-face discussion within 24 hours between the staff involved in the ESS/ESI and the resident.	**It was not the intent of KIDS Behavioral Health of Montana to create a seclusion in its implementation of the previous Loss of Opportunity Policy and Procedure. Upon further review, KBH has discontinued the use of Loss of Opportunity and implemented its Special Intervention: Intensive Focus Policy and Procedure (attached) on 7/27/05. Nurses training occurred on 7/19/05 and all clinical staff received the policy and procedure on 7/22/05. Health Information Management will audit resident charts to ensure appropriate documentation is occurring specific to continued access to treatment, therapy and education. If an Emergency Safety Situation or Emergency Safety Intervention (ESS/ESI) occurs while a resident is on Intensive Focus, KBH will follow our policy and procedure on seclusion and/or restraint.**	**7/27/05**

7. The use of excessive chemical restraint cause the resident undue physical discomfort, harm, and pain.	**In order to conform with the guidelines required in this Statement of Deficiencies, KBH is implementing a new Emergency Medication Policy and Procedure (draft policy attached) and revising our existing Seclusion and Restraint Policy and Procedure to include emergency medications as an ESI (draft policy to be forwarded upon completion). Audit procedures will be performed by nursing staff and reviewed by the Director of Nursing (DON) to include debriefing, guardian contact and use of emergency medications. Our target date is 9/12/05 for revision of the Seclusion and Restraint Policy and Procedure and full implementation of the Emergency Medications Policy and Procedure.**	**9/12/05**

Deficiency	Plan of Correction	Completion Date
"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Seclusion and Restraint" "reviewed / revised 4/27/05. XI. Post-Intervention Assessment A. Debriefing I 1 Within 24 hours after the use of restraint or seclusion, staff involved in an Emergency Safety Intervention and the resident must have a face-to-face discussion. *** B. Debriefing II 1 . Within 24 hours after the use of restraint or seclusion, all staff involved in the Emergency Safety Intervention, and appropriate supervisory and administrative staff, will conduct a debriefing session, *** C. Initiation/Facility/Documentation of Debriefing I/II 1. Debriefings may be conducted on the Monday following a weekend occurrence of restraint or seclusion at the discretion of the Clinical Director. And; **JCAHO 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation / Developmental Disabilities Services** *** **SC.2 The organization has written policies and procedures that govern the use of seclusion or restraint.** *** **ER. 1 The organization has a written plan describing the manner in which psychiatric and medical emergency services are provided.** **The intent of the rules is not met as evidenced by:** 1) Surveyor's review of resident #1's Chart. **Findings:** 1. "Emergency Safety Situation/Intervention Report Forms" for May 2005 for "drugs used as restraint' dated 4/8/05 ordered at 830, 4/9/05 ordered at 1730, 4/10/05 ordered at 1110, 4/10/05 ordered at 1820, 4/13/05 ordered at 1758, 4/16/05 ordered at 1140, 4/19/05 ordered at 1630, 4/25/05 ordered at 2030, and 4/26/05 ordered at 1625, do not have "documentation of "Debriefing I" in the resident's record.	**In order to conform with the guidelines required in this Statement of Deficiencies, KBH is implementing a new Emergency Medication Policy and Procedure (draft policy attached) and revising our existing Seclusion and Restraint Policy and Procedure to include emergency medications as an ESI (draft policy to be**	**9/12/05**

2. "Emergency Safety Situation/Intervention Report Forms" for May 2005 for "physical restraint" dated 4/25/05 ordered at 2030, 4/16/05 ordered at 1140, 4/13/05 ordered at 1800, 4/10/05 ordered at 1110, and 4/8/05 ordered at 820 do not have "documentation of "Debriefing II" in the resident's record. 3. "Emergency Safety Situation/Intervention Report Forms" for "drugs used as restraint" dated 4/28/05 ordered at 1315 does not have "documentation of "Debriefing II" "in the resident's record". 4. "Emergency Safety Situation/Intervention Report Forms" for "seclusion" dated 4/13/05 ordered at 1820 does not have "documentation of "Debriefing 1" and does not have "documentation of "Debriefing II" "in the resident's record". 5. "Emergency Safety Situation/Intervention Report Forms" do not have a record of "Debriefing 1" and "Debriefing II" for the 17 incidents of seclusion and restraint used between 5/7/05 and 5/19/05.	forwarded upon completion). Audit procedures will be performed by nursing staff and reviewed by the Director of Nursing (DON) to include debriefing, guardian contact and use of emergency medications. Our target date is 9/12/05 for revision of the Seclusion and Restraint Policy and Procedure and full implementation of the Emergency Medications Policy and Procedure.	

"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Seclusion and Restraint" "reviewed / revised 4/27/05. Procedure *** X. Notification of Parent(s) or Legal Guardian A. KBH will notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each Emergency Safety Intervention. B. Staff must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the Emergency Safety Intervention, including the date and time of notification and the name of the staff person providing the notification. C. Each unsuccessful attempt to notify the parent(s) or legal guardian(s) or disconnected phone numbers will be documented as well as any messages left for the parent(s) or legal guardian(s) to contact KBH. And; **Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation / Developmental Disabilities Services** *** **SC.2 The organization has written policies and procedures that govern the use of seclusion or restraint.** *** **CA.4 Whenever services are provided to a child or adolescent, a mechanism exists for coordinating and facilitating the family's and/or guardian's involvement throughout treatment.** *** CA-4.1 At a minimum this mechanism is designed to CA.4.1.1 involve the family or guardian in the assessment, treatment, and continuing care of the individual served;		

Deficiency	Plan of Correction	Completion Date
The intent of the rules is not met as evidenced by: 1) Surveyor's review of resident #1's Chart. **Findings:**		
1. Resident record does not have documentation that the parent or guardian was notified of the use of "physical restraint" for the following dates and time: 4/8/05 at 830, 4/10/05 at 2012, 4/13/05 1800, 4/16/05 1140, and 4/25/05 at 2030.	Documentation was present in the resident's chart for 4/8/05 at 830 (Attachment C); 4/10/05 at 2012 (Attachment G); 4/16/05 at 1140 (Attachment D); and 4/25/05 at 2030 (Attachment E). Parent/guardian notification is addressed on page two of the nursing documentation. Lana Schaffer will audit the documentation daily in Morning Meeting.	7/2/05
2. Resident record does not have documentation that the parent or guardian was notified of the use of "drugs used as restraint" for the following dates and time: 4/9/05 at 1730, 4/28/05 at 1315. 5/15/05 at 1425, 5/11/05 at 1530, 5/10/05 at 1600, 5/10/05 at 1400, 5/7/05 at 1500, 5/7/05 at 1055, and 5/4/05 at 1335.	Documentation was present in the resident's chart for 4/28/05 at 1315 (Attachment H); 5/10/05 at 1400 (Attachment I); 5/7/05 at 1500; 5/7/05 at 1055 (Attachment J); and 5/4/05 at 1335 (Attachment K). Parent/guardian notification is addressed on page two of the nursing documentation. Lana Schaffer will audit the documentation daily in Morning Meeting.	7/2/05
3. Resident record does not have documentation that the parent or guardian was notified of the use of "seclusion" for the following date and time: 4/13/05 at 1820	**In order to conform with the guidelines required in this Statement of Deficiencies, KBH is implementing a new Emergency Medication Policy and Procedure (draft policy attached), and revising our existing Seclusion and Restraint Policy and Procedure to include emergency medications as an ESI (draft policy to be forwarded upon completion). Audit procedures will be performed by nursing staff and reviewed by the Director of Nursing (DON) to include debriefing, guardian contact and use of emergency medications. Our target date is 9/12/05 for revision of the Seclusion and Restraint Policy and Procedure and full implementation of the Emergency Medications Policy and Procedure.**	9/2/05
"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Seclusion and Restraint" "reviewed / revised 4/27/05. Procedure I. Definitions: A. Drug used as Restraint: Any drug that is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others, has the temporary effect of restricting the resident's freedom of movement and is not a standard treatment for the resident's medical or psychiatric condition. And; **"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Resident Rights Plan "reviewed / revised 2/25/04"**		

Purpose: *** 4. Each resident will receive individualized treatment, which will include the following: a. The provision of adequate and humane services regardless of sources of financial support; b. The provision of services within the least restrictive environment possible; And; **Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation / Developmental Disabilities Services** *** **SC.2 The organization has written policies and procedures that govern the use of seclusion or restraint.** SC.2.1 Using seclusion or restraint requires clinical justification. SC.2-1.1 Seclusion or restraint is used only to prevent the individual served from injuring himself/herself or others or to prevent serious disruption of the therapeutic environment. *** **PI.2 The organization has a written plan or policies and procedures that describe the rights of patients and the means by which these rights are protected and exercised.** *** PI.2.1.3 each patient receives individualized treatment, including at least the following: PI.2.1.3.1 providing adequate and humane services regardless of the source(s) of financial support, PI.2.1.3.2 providing services within the least restrictive environment possible, **The intent of these rules are not met as evidenced by:** 1) Surveyor's review of resident #1's Chart. **Findings:** 1. From 4/1/05 to 5/3/05 "drugs used as restraint" were classified as "emergency safety situation" requiring an "emergency safety intervention" 7 times. During this timeframe "drugs used as restraint" were not classified as "emergency safety situation" requiring the "emergency safety intervention" 4 times. 2. "Physician's order" for resident #1 dated 5/4/05 at 1335, 5/5/05 at 1530, 5/5/05 at 1340, 5/6/05 at 2100, 5/6/05 at 1915, 5/7/05 at 1500, 5/705 at 1055, 5/8/05 at 1015, 5/9/05 at 1350, 5/10/05 at 1400, 5/10/05 at 1600, 5/11/05 at 805, 5/11/05 at 1530, 5/13/05 at 1420, 5/15/05 at 1425, and 5/19/05 at 1730 approve "drugs used as constraint." These incidents are not classified as "emergency safety situation" on the "Nursing Document". 3. Drugs used as restraint without an "Emergency Safety Situation" violate residents "right" to adequate and humane services. 4. drugs used as restraint without an "Emergency Safety Situation" violate residents "right" "to provision of services within the least restrictive environment possible".	**In order to conform with the guidelines required in this Statement of Deficiencies, KBH is implementing a new Emergency Medication Policy and Procedure (draft policy attached) and revising our existing Seclusion and Restraint Policy and Procedure to include emergency medications as an ESI (draft policy to be forwarded upon completion). Audit procedures will be performed by nursing staff and reviewed by the Director of Nursing (DON) to include debriefing, guardian contact and use of emergency medications. Our target date is 9/12/05 for revision of the Seclusion and Restraint Policy and Procedure and full implementation of the Emergency Medications Policy and Procedure.**	**9/12/03**

Deficiency	Plan of Correction	Completion Date
"Kids Behavioral Health of Montana, Inc. Policy and Procedure: Treatment Plan Policy—RTC" "reviewed / revised 12/29/04" *** 2. Master Treatment Plan and Reviews d. Treatment plan reviews occur: *** 2) Whenever a change in status occurs necessitating special interventions, e.g., increase in number of ESIs (a special staffing form may be utilized for this update). And; **Kids Behavioral Health of Montana, Inc. Policy and Procedure: Education Plan and Policy Manual** Mission Statement - The education staff is committed to: Providing a quality educational experience for students, meeting their individual needs and interests. *** VIII. Class Structure and Procedure *** All students shall attend school as part of treatment process *unless otherwise indicated* through a decision of the treatment team. And; **Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation / Developmental Disabilities Services** CA.7 The organization has a policy designed to promote access to educational services for each child or adolescent served when treatment interventions necessitates a significant absence from school CA.7.1 The educational services are designed to meet the child's or adolescent's treatment needs and to provide educational continuity. **The intent of the rules is not met as evidenced by:** 1)Surveyor's review of resident #1's "Master Treatment Plan and Review /Update" of 3/30/05 and 4/26/05. 2) Surveyor's review of resident #1's "Kids Behavioral Health Weekly Education Notes" for April 2005 and May 2005. 3) Surveyor's review of the resident #1's "The Resident Locator Sheet" for April 2005 and May 2005. 4) Surveyor's review of resident #1's Chart. **Findings:** 1. Resident was unable to attend school on days she was placed on LOO. The "Master Treatment Plan" was not updated to reflect change in "Objective 4. 1: "will attend class every day." 2. Resident was unable to attend school on days she was placed on LOO. This was not documented as a decision of the treatment team. 3. Resident was not allowed to attend school on days she was placed on LOO. Resident received a grade of "0" for 20 of the 21 days placed on LOO. Grade should have been "ng" (no grade) as this does not affect Average.	Anne Dodge, Principal will train teachers on documenting educational assignments given to residents on IF. This will be done on the weekly education review form.	8/5/05

4. The educational services are not designed to meet the residents treatment needs and to provide educational continuity while on LOO.	The resident's treatment needs were being met but documentation was not present (see #2, page 9).	8/5/05

SIGNATURE Pam B. Broughton DATE 8/26/05

TITLE CEO

Return to: Beal Mossman, Mental Health Surveyor
DPHHS/Licensure Bureau, Suite D
2121 Rosebud Drive
Billings, Mt 59102
Phone: 406-855-7624

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: **Emergency Medications**		**PAGE 1 of 3**	
FUNCTIONAL AREA: **Provision of Care, Treatment and Services; Medication Management**		**REFERENCES: PC.12.10, .12.20, .12.30, PC.12.40, PC.12.50, PC.12.60; PC.12.70, PC.12.110; MM.3.10, MM.3.20, MM.4.10, MM.6.10; HCFA – H.R. 4365**	
EFFECTIVE DATE: ***Draft 8/18/05***		**APPROVED BY: Executive Committee**	
REVIEWED/REVISED:	REVIEWED/REVISED:	REVIEWED/REVISED:	REVIEWED/REVISED:

POLICY:

KIDS Behavioral Health of Montana's primary focus is to protect the rights of residents and to ensure that care and treatment are provided in a safe and secure setting. Therefore, Emergency Medications are used to assist the resident to regain emotional/behavioral control or when there is imminent risk of a resident physically harming himself or herself, or others, including staff members. Non-physical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response.

The use of pharmacological interventions **poses an inherent risk** to the physical safety and psychological well being, loss of dignity, and violation of resident rights. Thus Kids Behavioral Health emphasizes its commitment to continually explore ways to prevent, reduce, and strive to eliminate the use of pharmacological intervention use through effective Performance Improvement initiatives.

This standard may vary according to individual sate or licensure requirement.

I. VOLUNTARY USE OF EMERGENCY MEDICATION BY RESIDENT or PRN

Emergency Medication refers to the procedure in which a resident receives a PRN medication used to regain emotional/behavioral control that is on the Medication Administration Record and Master Treatment Plan and maintains the resident's ability to participate therapeutically in the milieu.

II. EMERGENCY MEDICATION USED IN CONJUNCTION WITH PHYSICAL RESTRAINT

Clinical justification for the use of an Emergency Medication refers to the procedure in which a resident receives a PRN medication used to regain emotional/behavioral control that is on the Medication Administration Record and Master Treatment Plan when the resident is in a Physical Restraint and when there is imminent risk of a resident physically harming himself or herself, or

others, including staff members. Non-physical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response.

PROCEDURE:

1. Criteria for Voluntary use of an Emergency Medication

   a. The resident has received a psychological evaluation on admission and aggressive/assaultive behaviors have been identified and have been listed as a problem with measurable objective goals and interventions on the Master Treatment Plan. Or these behaviors may be manifested after admission and added as a problem to the Master Treatment Plan.

   b. The resident on admission has identified behavioral triggers and self-calming interventions on the De-escalation preference form.

   c. The attending physician/L.I.P has written an order for a PRN medication that includes:

      1) Specific reason for the medication (i.e., agitation, aggressive behavior, uncontrollable rage, assault on others, self-injurious behavior, etc.)
      2) Dosage
      3) Route (i.e., By Mouth or Intramuscular)
      4) Time interval (i.e., every four hours)

2. Before dispensing, a pharmacist or physician reviews all medication orders except in urgent situations when the resulting delay would harm the resident. In the event the pharmacist is not in the facility or available by telephone, they will review all orders as soon as possible (i.e. the following morning).

   a. The Pharmacist will review all medication orders for the following:

      1) The appropriateness of the drug, dose, frequency and route of administration
      2) Therapeutic duplication
      3) Real or potential allergies or sensitivities
      4) Real or potential interactions between the order medication and other medications, food and laboratory values.
      5) Other contraindications
      6) Variation from normal criteria for use
      7) Other relevant medical-related issues or concerns

   b. All concerns, issues, or questions are clarified with the individual prescriber before dispensing the medication.

   c. The staff nurse enters the medication on the Medication Administration Record and the resident's Master Treatment Plan at the time of the order.

d. All PRN medications will be reviewed monthly during the Master Treatment Plan review by the clinical team for the number of times it has been utilized during the month and assess the appropriateness of its continued use. Based on these findings, the medication may be renewed for continued use, the resident's routine medication regime may be adjusted to decrease the need for the PRN medication, or the medication may be discontinued if it is deemed not to be necessary.

3. Notification of need for Emergency Medication

   a. The resident may self-report that they are feeling restless, anxious, aggressive, agitated, combative or out of control.

      1) The resident may request of the nurse that a medication be given to them to assist them in regaining emotional/behavioral control.
      2) After assessing the resident, observing the resident for "trigger behaviors" that they disclosed on admission (I.e. pacing, stiff posture, yelling/swearing, etc.) and after suggesting de-escalating techniques the resident has listed as their personal preferences, the nurse may administer the PRN medication if the professional judgment of the nurse it is warranted (i.e. not demonstrating drug seeking behaviors).

         a) The nurse will encourage the resident to take the medication orally if more than one route is ordered.

      3) The Mental Health Associate or Nurse might observe the resident demonstrating "trigger behaviors" that they disclosed on admission. The Mental Health Associate /Nurse will make the resident aware of their behaviors and suggest de-escalating techniques; including using a PRN medication if the resident is in agreement, before they lose emotional/behavioral control.
      4) The nurse will monitor the resident for efficacy and side-effects after 30 minutes and 90 minutes and document the resident's response and any adverse reactions.

4. Initiating an Emergency Medication with the resident in a Physical Restraint

   a. Whenever possible, the nurse will offer the resident non-physical and non-pharmacological interventions as the first choice of intervention if the resident can contract to remain safe.

   b. The nurse will determine and document when there is imminent risk of a resident physically harming himself or herself, or others, including staff members.

   c. The nurse will first offer the resident the Emergency Medication orally. If the resident is in agreement, the medication will be given orally.

   d. If the resident does not agree to take the medication by mouth and continues to demonstrate unsafe behavior, necessitating a continuation of the physical restraint and will not contract to be safe, the nurse may give the medication intramuscularly (if

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: **Seclusion and Restraint**		**PAGE 1 of 15**	
FUNCTIONAL AREA: **Provision of Care, Treatment and Services**		**REFERENCES: PC 4.40, PC 10, PC 12**	
EFFECTIVE DATE: 6/1/01		**APPROVED BY: Executive Committee, MSEC, Governing Board**	
REVIEWED/REVISED: **9/18/01**	**REVIEWED/REVISED:** **11/28/01**	**REVIEWED/REVISED:** **2/27/02**	**REVIEWED/REVISED:** **5/22/02**
REVIEWED/REVISED **11/20/02**	**REVIEWED/REVISED** **2/26/03**	**REVIEWED/REVISED** **5/26/04**	**REVIEWED/REVISED** ***Draft 4/1/05***
REVIEWED/REVISED **4/27/05**	**REVIEWED/REVISED** ***Draft 9/9/05***	**REVIEWED/REVISED**	**REVIEWED/REVISED**

POLICY STATEMENT:

KIDS Behavioral Health (KBH) of Montana's primary focus is to protect the rights of residents and to ensure that care and treatment are provided in a safe and secure setting. Therefore, restraint and seclusion are used only in an Emergency Safety Situation when there is an imminent risk of a resident physically harming him/herself or others, including staff members. Non-physical interventions are the first choice as an intervention unless safety issues demand an immediate physical response.

The use of Restraint and Seclusion poses an inherent risk to the physical safety and psychological well being, loss of dignity, and violation of resident rights. Thus KBH emphasizes its commitment to continually explore ways to prevent, reduce and strive to eliminate the use of Restraint and Seclusion use through effective Performance Improvement initiatives. KBH is committed to the following principles:

- A major focus of Continuous Process Improvement is the prevention and reduction of the use of Restraint and Seclusion.
- It is leadership's role at KBH to create an environment that minimizes the incidents that give rise to Restraint and Seclusion use.
- Emphasis is placed on the prevention of emergencies that have the potential to lead to the use of Restraint and Seclusion.
- Providing effective alternative behavioral management approaches.
- The preservation of resident's safety and dignity when Restraint and Seclusion are used.
- That staff are aware of and sensitive to the fact that Restraint or Seclusion used with residents who have pre-existing medical or physical condition(s) or with residents with a history of sexual or physical abuse are at greater risk.
- That the role of the family/guardian is important in decisions and activities that are related to the use of Restraint and Seclusion.

- That the resident has the right to be free from Restraints and Seclusion of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff.
- That as a mental health agency, treatment is provided to residents with severe mental illnesses who are, at times, dangerous to themselves or others and that the use of Restraint and Seclusion may be necessary to prevent injury or death.

Additionally, because the use of seclusion and restraint poses an inherent risk to the physical safety and psychological well being of residents and staff, these extremely restrictive measures are only used in emergencies when:

- a resident's behavior presents an imminent risk of physical harm to him/herself or others, including staff.
- less restrictive measures have been tried but have failed to ensure the safety in the milieu.
- safety issues demand an immediate physical response.

When it becomes necessary to seclude or restrain a resident, every attempt will be made to maintain the resident's right to dignity, respect, privacy and safety. KBH prohibits the use of seclusion or restraint for any other purpose, such as discipline, coercion, convenience, or retaliation.

Two staff members must be present at the scene prior to putting "hands on" any resident. The two staff members are identified as 1) the staff member directly supervising the resident and 2) the nurse that the staff member has solicited for assistance. Assistance may also be solicited from other specified members of the clinical team. In rare Emergency Safety Situations, another mental health associate (MHA) may be solicited for assistance by the supervising staff member. This decision will be reviewed for determination of legitimacy and subject to disciplinary action if determined that the supervising staff member could have, but failed to, call for a nurse or other specified clinical team staff for assistance.

If a resident sustains an injury during a seclusion and/or restraint procedure, the resident will be immediately assessed by a nurse, and then further evaluated by the medical physician for assessment of "serious injury." In the absence of the medical physician, the Medical Director will assess the injuries of the resident and document her/his assessment in the resident's chart. All resident injuries will be reviewed for adherence to this Policy and Procedure and proper Mandt procedures, and appropriate disciplinary action will be initiated for any substantiated violations.

PROCEDURE

I. DEFINITIONS:

A. **Abuse** – The willful infliction or injury, unreasonable confinement, intimidation or punishment, with resulting physical harm, pain or mental anguish. This includes staff neglect or indifference to inflection of injury or intimidation of one resident by another. Abuse includes such acts as:

- The rape, sexual assault, or sexual exploitation of a resident.
- The striking of a resident.
- The use of **excessive force** when placing a resident in bodily restraint.
- The use of bodily or chemical restraints on a resident, which is not in compliance with federal and state laws and regulations; and
- Threats, coercion or restrictive actions intended to influence the treatment decisions of a resident.

B. **Emergency Safety Intervention (ESI):** The use of restraint, seclusion or medication as an immediate response to an Emergency Safety Situation.

C. **Emergency Safety Situation (ESS):** A situation in which it is immediately necessary to restraint, seclude or administer an emergency medication to a resident to prevent imminent:
   - Probable death or substantial physical harm to the resident because the resident overtly or continually is threatening or attempting to commit suicide or serious bodily harm; or
   - Physical harm to others because of threats, attempts, or other acts the resident overtly or continually makes or commits, and preventive de-escalation, or verbal techniques have proven ineffective in defusing for injury. These situations may include serious incidences of shoving or grabbing others over their objections. Where the behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the resident, other residents, staff and others. These situations **do not include** verbal threats or verbal attacks.

D. Accompanying: The re-direction or guidance of a resident who does not physically resist moving with the staff member and situation does not escalate into a need to physically force the resident to move. The term *accompanying* may include the temporary touching of holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a resident who is acting out to walk to a safe location.

E. Escorting – Use of physical force by a staff member to move or direct a resident to another location. Escorting is a type of *personal restraint*. Escorting does not include *accompanying* a resident.

F. Imminent Significant Risk - Risk that is immediate. Given the situation, a prudent person must be able to conclude that bodily harm will occur to either the resident or to another person if there is no immediate intervention. Imminent significant risk does included the probability of imminent harm resulting from a resident running away.

G. **Mechanical Restraint:** Any device attached or adjacent to the resident's body that s/he cannot easily remove that restricts freedom of movement or normal

access to his or her body. **THE USE OF MECHANICAL RESTRAINT IS PROHIBITED AT KBH.**

H. **Personal Restraint:** The application of physical force, including *Escorting*, without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding the resident without undue force in order to calm or comfort him or her, or holding a resident's hand or arm to safely escort a resident from one area to another.

I. **Restraint**: A "personal restraint," "mechanical restraint," or "drug used as a restraint" as defined in this policy.

J. **Seclusion**: The involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

K. **Serious Injury**: Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

L. **Time Out**/Quiet Time: A procedure in which the resident , on the resident's own initiative, cooperatively enters and remains in a designated area for a period of time. (Time Out, and similar interventions intended to be preventive are not appropriate in emergency situations.) The resident may terminate self-initiated use of Time Out at any time. A self-directed **may not** be enforced under any circumstances.

M. **Clinical Time Out**: The involuntary confinement of a resident not alone in a room or a specific area in which the resident is physically prevented from leaving for any period of time. This would include any restriction of movement that is physically or psychologically imposed including open door seclusion and Time Out, if the mental health worker blocking the doorway with his/her body prevents the resident from leaving. Clinical Time Out is also known as *Staff Directed Time-Out* or *Time Out with Help* as defined by JCAHO and HICFA.

1. Level I Clinical Time Out Confinement duration of 16+ minutes
2. Level II Clinical Time Out Confinement duration of 1-15 minutes

N. Emergency Medication – The resident receives a P.R.N. medication used to regain emotional/behavioral control that is on the Medication Administration Record and Master Treatment Plan when the resident is in a Personal Restraint and when there is imminent risk of a resident physically harming him/herself, or others, including staff members. The resident is not overly sedated and can rejoin the milieu and participate in their treatment. (See Emergency Medication Policy)

O. Chemical Restraint – The use of any chemical including pharmaceuticals, through topical application, oral administration, injection, or other means, solely for the purpose of immobilizing, sedating or restraining a resident as a mechanism of control and is not a standard treatment for the resident's medical or psychiatric condition. **THE USE OF CHEMICAL RESTRAINT IS PROHIBITED AT KBH.**

J. **Other Licensed Practitioner:** Registered and Licensed Practical Nurses (licensed in the State of Montana), trained in the use of Emergency Safety Interventions, and authorized by KBH to conduct a face-to-face assessment of the physical and psychological well being of residents.

II. ADMISSION

A. During the admission process the resident's parent(s) or legal guardian(s) are given information about the KBH's policy regarding the use of seclusion and restraint during an Emergency Safety Situation that may occur while the resident is at KBH. The restraint and seclusion policy will be communicated in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, KBH will provide interpreters or translators.

B. The signed consent form will document that information about the use of seclusion and restraint has been provided. An acknowledgment in writing will be obtained from the resident's parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an Emergency Safety Situation. This acknowledgment will be filed in the resident's record.

C. A summary of the facility policy will be provided to the resident and to the resident's parent(s) or legal guardian(s). The complete copy of the policy will be provided if requested.

D. KBH will provide the resident's parent(s) or legal guardian(s) with the phone number and address of the State Protection and Advocacy organization.

•Montana Advocacy Program
400 North Park Ave., Second Floor
P.O. Box 1681
Helena, MT 59620
Telephone: (406) 449-2344 (Voice/TTD)

III. PLAN OF CARE

A. An initial assessment shall be performed for the resident's plan of care, during which information is obtained by the nurse, physician and therapist that could

help minimize the Emergency Safety Interventions, including information that would place the resident at greater risk during an Emergency Safety Intervention, such as:

1. Any pre-existing medical conditions.
2. Physical limitations or disabilities.
3. History of dangerous behaviors while in seclusion.
4. History of sexual or physical abuse.

B. KBH prohibits the use of PRN (as needed) or standing orders for Emergency Safety Interventions.

C. The KBH Treatment Team will review each resident's admission information as to a history of aggressive impulses and behavior. When a resident has had occurrences of discrete episodes of failure to resist aggressive impulses that may result in serious assaultive acts toward self or others, the treatment team will identify this in the resident's Treatment Plan as a "Problem." Specified interventions and goals will be determined by the Treatment Team and addressed in the resident's Treatment Plan. The Treatment Plan may include the use of seclusion and/or restraint interventions.

- A Treatment Plan for aggressive behaviors will also be developed by the Treatment Team for any resident who has had no previous pre-admission history of aggressive behaviors but who demonstrates aggression after admission that compromises the safety of the resident or others.

D. A resident's treatment plan may include specific measures that should be incorporated in the event that Emergency Safety Interventions necessary, e.g., specification of the gender of staff monitor, restriction on the use of leather restraints because of abuse history, instructions to notify the family or guardian, etc.

IV. IMPLEMENTING SECLUSION

A. Non-physical interventions are the first choice interventions unless safety issues demand an immediate physical response. When a resident's behavior presents an imminent risk to him/herself or others and less restrictive measures (e.g., verbal redirection, de-escalation attempts, reduction of stimuli, a time out, etc.) have been tried without success, the resident will be assessed for the need to seclude.

B. If the resident is not being physically held, enough trained staff to safely intervene will be assembled. The designated leader will verbally direct the resident and attempt to de-escalate the situation. If this does not work, the staff will intervene at the direction of the leader and use only enough force to safely contain the resident and move him/her to the seclusion area.

C. In emergency situations, a nurse may initiate a seclusion procedure followed immediately by a call to the physician to report the circumstances and obtain a written or verbal order. The date and time of this consultation is documented in the resident's medical record. All physicians' orders shall comply with Section VII of this policy.

D. At the implementation of seclusion, potentially dangerous items are removed from the room and the resident (e.g., shoes, pencils, pens, jewelry), which requires searching the resident's pockets and clothing using the guidelines in the *Search Policy*.

E. The nurse will inform the resident of the reason for the seclusion and describe the criteria for discontinuing the intervention, e.g., "You have been secluded because you have tried repeatedly to assault your roommate. When you can calm down and sit quietly for five minutes, you can come out of the room."

F. The nurse will assign a trained Mental Health Associate or Unit Clerk to visually monitor the resident as provided in Section IX. *Monitoring Restraint and Seclusion* of this policy.

G. In the rare event of a lengthy seclusion, bathroom and fluids are offered hourly or as needed, and meals/snacks are offered at scheduled times unless this is contraindicated by the resident's documented clinical status. In this case, the regular meal or snack will be offered as soon as possible. These intervals clearly present opportunities to evaluate readiness for the intervention to be discontinued.

H. Locked seclusion may be contraindicated if:

1. The resident is claustrophobic or otherwise extremely fearful of being locked in a room alone.
2. The resident has a history of abuse/neglect in which he/she was locked alone in a room.
3. The use of locked seclusion increases the resident's level of agitation.
4. The resident is on Suicide Precautions.
5. The resident has a history of inflicting self-harm during seclusion or becomes a danger to self during seclusion.

V. IMPLEMENTING PERSONAL RESTRAINT

A. When a resident's behavior presents an imminent risk to him/herself or others and less restrictive measures (e.g., verbal redirection, de-escalation attempts, reduction of stimuli, time out, seclusion, etc.) have been tried without success, the resident will be assessed for the need to be restrained. KBH only utilizes Personal Restraint.

1. The staff member who is interacting with the resident and observing the behavior of the resident will request assistance from one of the nursing staff.
2. The nursing staff member will:

    a. Consult with the staff member.
    b. Assess the situation.
    c. Determine the necessity for physical intervention with the resident in order to protect the safety of the resident or others.
    d. If an Emergency Safety Intervention is deemed necessary to assure the safety of the resident or others, the intervention will be initiated by the nurse subject to a physician's order as provided in Section XII of this policy.
    e. The nurse will assume the role of leader of the Emergency Safety Intervention and will monitor the following parameters:

        1) Procedure according to policies and procedures.
        2) Physical and psychological status of the resident.
        3) Cessation of the procedure or other appropriate actions to provide safety for the resident and/or others.

3. Exceptions that allow for immediate intervention with out pre-approval by a nurse or nurse initiation of personal restraint include, but are not limited to, the following examples:

    a. Physical altercation between two peers.
    b. Physical attack by a resident of a staff member.
    c. Life threatening self-abusive behaviors.
    d. Life threatening injuries.

VI. DISCONTINUING AN EMERGENCY SAFETY INTERVENTION

A. As soon as the resident is calm and assessed as no longer a danger to him/herself or others, the Emergency Safety Intervention is discontinued.

B. The nurse will determine, direct and communicate the plan for release to the resident and staff.

C. The resident will have an opportunity to process the procedure with all trained staff persons who were involved in the Emergency Safety Intervention. At this time, staff and resident will:

1. Attempt to assure the resident's understanding of why the seclusion was necessary.
2. Describe the behavioral expectations for reintegration into the community.
3. Discuss circumstances:

a. Leading up to the seclusion/restraint procedure.
b. Opportunities for making different choices.
c. Identify anger tools.
d. Identify other coping strategies.

4. The resident will also be offered an opportunity to shower and clean up.

VII. ORDERS FOR RESTRAINT OR SECLUSION.

A. Orders for restraint or seclusion must be by a physician.

B. If the resident's treatment team physician is available, only he or she can order restraint or seclusion. If the resident's treatment team physician is unavailable, the physician covering for the treatment team physician can order restraint or seclusion.

C. A physician must order the least restrictive Emergency Safety Intervention that is most likely to be effective in resolving the Emergency Safety Situation based on consultation with staff.

D. If the order for restraint or seclusion is verbal, the verbal order must be received by a nurse while the Emergency Safety Intervention is being initiated by staff or immediately after the Emergency Safety Situation ends. The physician must verify the verbal order in a signed written form in the resident's record. The physician must be available to staff for consultation, at least by telephone, throughout the period of the Emergency Safety Intervention.

E. Each order for restraint or seclusion must:

1. Be limited to no longer than the duration of the Emergency Safety Situation.
2. Under no circumstances exceed the following time frames according to age:

a. 4 hours for residents ages 18 to 21.
b. 2 hours for residents ages 9 to 17.
c. 1 hour for residents under age 9.

F. Each order for restraint or seclusion must include:

1. The name of the ordering physician.
2. The date and time the order was obtained.
3. The Emergency Safety Intervention ordered, including the length of time for which the physician authorized its use.

G. A physician who orders the use of restraint or seclusion must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The physician ordering the use of restraint or seclusion must:

1. Consult with the resident's treatment team physician as soon as possible and inform the team physician of the Emergency Safety Situation that required the resident to be restrained or placed in seclusion.
2. Document in the resident's record the date and time the team physician was consulted.

H. The physician must sign the restraint or seclusion order in the resident's record as soon as possible and within the time frame of KBH's policy.

VIII. ASSESSMENT AND DOCUMENTATION

A. Nursing staff are responsible for performing an initial and every 15 minutes thereafter assessment of a resident in restraint or seclusion to include the following:

1. Signs of any injury associated with applying restraint or seclusion.
2. Nutrition and hydration.
3. Circulation and range of motion in the extremities.
4. Vital signs.
5. Hygiene and elimination.
6. Physical and psychological status and comfort.
7. Readiness for discontinuation of restraint or seclusion.

B. Within 1 hour of the initiation of the Emergency Safety Intervention a physician, or other licensed practitioner* trained in the use of Emergency Safety Interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to:

1. The resident's physical and psychological status.
2. The resident's behavior.
3. The appropriateness of the intervention measures.
4. Any complications resulting from the intervention.

C. Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

1. Each order for restraint or seclusion.
2. The time the Emergency Safety Intervention actually began and ended.
3. The time and results of the 1-hour assessment
4. The Emergency Safety Situation that required the resident to be restrained or put in seclusion.
5. The name(s) of staff involved in the Emergency Safety Intervention.

C. KBH will maintain a record of each Emergency Safety Situation, the interventions used, and their outcomes.

IX. MONITORING RESTRAINT AND SECLUSION.

A. RESTRAINT

1. Clinical staff trained in the use of Emergency Safety Interventions must be physically present, continually assessing and monitoring the physical and psychological well being of the resident and the safe use of restraint throughout the duration of the Emergency Safety Intervention. This staff will document specific resident behaviors every 5 minutes for the first fifteen minutes and then every 15 minutes on the *Seclusion and Restraint Report Form.*
2. If the Emergency Safety Situation continues beyond the time limit of the order for the use of restraint, a registered nurse must immediately contact the ordering physician to receive further instructions.
3. A physician, or other licensed practitioner* permitted by the state and the facility to evaluate the resident's well-being and trained in the use of Emergency Safety Interventions, must evaluate the resident's well-being immediately after the restraint is removed.

B. SECLUSION

1. Clinical staff, trained in the use of Emergency Safety Interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well being of the resident in seclusion.
2. A room used for seclusion must:

    a. Allow staff full view of the resident in all areas of the room.
    b. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

3. If the Emergency Safety Situation continues beyond the time limit of the order for the use of seclusion, a nurse must immediately contact the ordering physician to receive further instructions.
4. A physician, or other licensed practitioner* permitted by the state and the facility to evaluate the resident's well-being and trained in the use of Emergency Safety Interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

X. NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN(S).

A. KBH will notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each Emergency Safety Intervention.

B. Staff must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the Emergency Safety Intervention, including the date and time of notification and the name of the staff person providing the notification.

C. Each unsuccessful attempt to notify the parent(s) or legal guardian(s) or disconnected phone numbers will be documented as well as any messages left for the parent(s) or legal guardian(s) to contact KBH.

XI. POST-INTERVENTION ASSESSMENT

A. DEBRIEFING I

1. Within 24 hours after the use of restraint or seclusion, staff involved in an Emergency Safety Intervention and the resident must have a face-to-face discussion.
2. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident.
3. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility.
4. The facility will conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s).
5. The discussion will provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

B. DEBRIEFING II

1. Within 24 hours after the use of restraint or seclusion, all staff involved in the Emergency Safety Intervention, and appropriate supervisory and administrative staff, will conduct a debriefing session,

2. The debriefing will include a that includes, at a minimum, a review and discussion of:

    a. The Emergency Safety Situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention.
    b. Alternative techniques that might have prevented the use of the restraint or seclusion.
    c. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

C. INITIATION/FACILITATION/DOCUMENTATION OF DEBRIEFING I/II

1. Debriefings may be conducted on the Monday following a weekend occurrence of restraint or seclusion at the discretion of the Clinical Director.

2. The Clinical Director or his designee is responsible for the following:

   a. Initiating Debriefing I/II.
   b. Facilitating Debriefing I/ II.
   c. Soliciting the signature of the resident or documenting that the resident declined/refused to sign.
   d. Documenting the Debriefing process.
   e. Collection and analysis of data for Performance Improvement.

3. Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

XII. MEDICAL TREATMENT FOR INJURIES

A. Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an Emergency Safety Intervention.

B. Staff must document in the resident's record, all injuries that occur as a result of an Emergency Safety Intervention, including injuries to staff resulting from that intervention.

C. Staff involved in an Emergency Safety Intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

XIII. REPORTING OF SERIOUS OCCURRENCES

A. The facility will report each serious occurrence to the Montana Department of Public Health and Human Services, Montana Licensing and Credentialing Department Division of Public Health and Human Services, Montana Advocacy Program, and Board of Visitors. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in this policy, and a resident's suicide attempt. This report must be made by no later than close of business the next business day after a serious occurrence. The report may be made by telephone or facsimile transmission. The report must include the following information:

   1. Name of the resident involved in the serious occurrence.

2. A description of the occurrence.
3. The name, street address, and telephone number of the facility.

B. Staff will notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence. The notification may be made by telephone.

C. Staff will document in the resident's record that the serious occurrence was reported to the agencies listed in XIII.A.including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by KBH.

D. In addition to the reporting requirements contained in paragraph XII.A. of this policy, a death of any resident must be reported to the Centers for Medicare and Medicaid Services (CMS) regional office in Denver, which report must be made no later than close of business the next business day after the resident's death. The report may be made by telephone. Staff must document in the resident's record that the death was reported to the CMS regional office.

E. If the occurrence is a sentinel event under JCAHO guidelines, voluntary reporting to JCAHO will be determined by the Quality Assurance Committee. Refer to KBH's Policy and Procedure for *Sentinel Event*.

XIV. APPLICATION OF TIME OUT

A. Time out is not seclusion, however, a resident in time out must never be physically prevented from leaving the time out area. If the resident is physically prevented from leaving the area of time-out, then the time out is seclusion and all requirements of this policy related to seclusion must be complied with.

B. Time out may take place away from the area of activity or from other residents (exclusionary), or in the area of activity or other residents (inclusionary).

C. Staff must monitor the resident while s/he is in time out.

XV. NOTIFICATION OF CLINICAL/ADMINISTRATIVE LEADERSHIP OF KBH

A. A member of clinical management (appropriate Team Lead, Nurse Lead, Director of Social Services, Director of Nursing) shall be notified of extended or multiple episodes of restraint or seclusion.

1. This information is presented, reviewed, and discussed daily Monday through Friday in Morning Meetings that are attended by clinical and administrative leaders of KBH.
2. Weekend occurrences of restraint or seclusion are reviewed during the Monday Morning Meeting following the weekend.

B. Multiple ESS/ESI episodes are defined as greater than three episodes of restraint or seclusion within a seven-day period.

C. When multiple or extended episodes of seclusion or restraint are identified for a resident, a Special Treatment Team Staffing is held and appropriate modifications and recommendations are made to the Treatment Plan.

XVI. TRAINING

A. Training on this policy for all direct-care staff members will occur according to the following schedules:

1. At the time of initiation of the policy.
2. After any procedural revisions of the policy.
3. During the Orientation Process for newly hired direct-care employees.
4. Annually.

B. Appropriate procedural training for all direct care staff members in regards to this policy consists of the following:

1. Mandt System: *Putting People First* with emphasis on de-escalation techniques – annually.
2. Cardio-Pulmonary Resuscitation (CPR) – annually.
3. Virtues Project – at Orientation.

C. Nurses will receive additional training and are required to pass competency criteria on the *One-Hour Assessment.*

D. Training attendance and competency testing will be recorded in the personnel files of appropriate direct-care staff members.

XVII. PERFORMANCE IMPROVEMENT

A. Individual Case Evaluations

1. All residents' treatment plan interventions are reviewed on both an *as needed* basis when special circumstances warrant, i.e., occurrence of multiple episodes of ESS/ESI as defined in XV.B.1, 2, and on a regular monthly (28 day) schedule.
2. Special Staffings for a resident may be initiated by any member of the Clinical, Administrative Leadership Team or Treatment Team of KBH after a resident has had multiple ESS/ESI episodes.
3. The resident's treatment plan reviews cover in part:

a. The frequency patterns, and effectiveness of specific behavior interventions.
b. Strategies to reduce the need for behavior interventions overall.
c. Specific strategies to reduce the need for use of seclusion or restraint when appropriate.

B. KBH collects data and performs internal audits on restraint and seclusion to:

1. Ascertain that restraint and seclusion are used only as Emergency Safety Interventions (ESI).
2. Assess injuries to residents and staff members.
3. Identify opportunities for incrementally decreasing the numbers of occurrences of seclusion and restraints and improving safety to residents and staff during restraint and seclusion use.
4. Identify any need to redesign care and/or training processes.

C. Data from the ESS/ESI Reports is collected on a daily basis and a monthly report is prepared by the Clinical Director. Monthly statistics are forwarded to the Risk Manager to be entered on the APO Report. Referrals are made immediately to the KBH Resident Advocate and appropriate supervisory staff when indicated.

1. Data statistics include, but are not limited to all data documented on the ESS/ESI Report Form.
2. Data statistics are reported by the Clinical Director to:

a. KBH Corporate's Risk Management Department monthly.
b. Executive Committee quarterly.
c. Governing Board quarterly.

From: "Pam M. Broughton" <PMBroughton@kidsbh.com>
To: <advocate@mtadv.org>
Date: 9/22/05 4:13PM
Subject: Response to Investigative Report of September 8, 2005

Dear Ms. Franks-Ongoy,

Please find the attached letter of response (MAP response.092205.pdf) and 11 supplemental documents for your review.

If you have any questions regarding our submission, please don't hesitate to contact me at the below referenced telephone number.

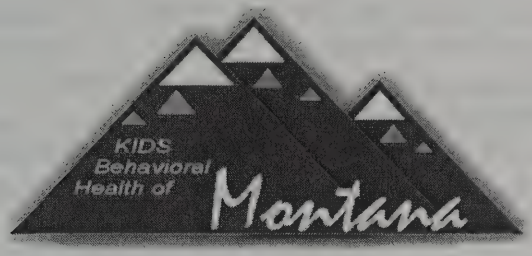
Respectfully submitted,

Pamela M. Broughton
Chief Executive Officer
KIDS Behavioral Health of Montana
55 Basin Creek Road, Butte, MT 59701
(406) 494-4183 - (406) 494-5869 fax
PMBroughton@KidsBH.com

CC: <RKemp@MT.Gov>, "Haire, Gene" <ghaire@mt.gov>, "Bill R. Vickers" <BRVickers@kidsbh.com>, <PatM@LuxanMurfitt.com>, "Carol A. Smith" <CASmith@kidsbh.com>

Appendix 3

Response from KIDS Behavioral Health (KBH) to MAP's Kathy R. Investigative Report



September 22, 2005

TO: Bernadette Franks-Ongoy, Executive Director
Montana Advocacy Program

FROM: Pam Broughton, Chief Executive Officer

Re: *Investigative Report of September 8, 2005*

The following will outline our response to your investigation report on resident JB on our Gold Girls Unit. We believe that the actions that we have taken address the specific concerns you have identified. Further, our response will address our analysis of residents' aggression and review of our clinical programs. During this review and analysis we have identified the following factors contributing to the occurrence of resident to resident assaults:

- Staff Supervision
- Staff Development and Training
- Program Structure

Be assured that KIDS Behavioral Health of Montana (KBH) is serious about solving the identified problems. Our goal is to provide quality care for our residents, using positive techniques that promote the individual's personal strengths. We will continue ongoing efforts to improve the quality of our programs for the children that we serve.

Following are the immediate steps that we are now taking to meet this particular challenge.

Recommendation #1
Increase Direct Care Staffing Grid *(See attached Staffing Grid)*

The following are the steps that were initiated prior to receipt of the draft MAP report to increase our direct care staff pool:

- Five new MHA orientees completed their two-week training course on September 9, 2005. They were immediately placed into rotation.
- Contract with local temporary agency for a Certified Nursing Assistants that will be placed in the MHA staffing grid immediately.
- Attended Montana Tech Career Fair September 15, 2005 for recruiting opportunity.
- Continuing to recruit for MHAs through newspaper, job services, North American Indian Alliance and recruiting agencies.
- Inexperienced employees must receive proper training prior to entering the MHA pool. Our current two-week training program includes MANDT, CPR, First Aid, and clinical program-specific training. *(See Attached Orientation Schedule)*
- Next Orientation is scheduled 9/26-10/7/05.

Leadership and Organizational Changes

Clinical Leadership changes effective September 13, 2005, are as follows:

- Promotion of Tawnya Mock from Admission Director to Program Director (a newly created position). Responsibilities include oversight of RTC, supervision of Program Leads (PLs), Assistant Program Leads (APLs), Mental Health Associates (MHAs), Activity Services and Education Department
- Valerie Marshall will assume the role of Admissions and Discharge Director
- Steve Heinz, PhD, Director of Clinical Services will continue supervision of therapists. Will add supervision of care managers, oversight of treatment planning to ensure adequate representation of all disciplines and compliance of all requirements, program development to include development of MHA group materials, evaluation of program structure and ongoing clinical staff development training.
- Lana Schaffer, RN appointed Director of Quality Assurance (a newly created position). The quality assurance/risk management function will now be separate from the Director of Nursing. Responsibilities will include the completion of investigations and reporting mandatory incidents to all outside agencies to ensure reporting requirement. This role will complement the Resident Advocate. Lana Schaffer will continue in the role of DON until a replacement is identified.
- Leadership team has implemented a procedure to offer clinical and administrative support, guidance and consultation to RTC personnel regarding unforeseen problems, decisions or incidents. *(See attached Leadership Schedule and AOC Checklist)*

Recommendation #2

Through our analysis several changes are being made to our treatment programs. These changes were also initiated prior to receipt of the draft MAP report.

- Implementation of Today/Tomorrow Positive Behavioral Support Program 8/31/05. Training was conducted by Steve Heinz, PhD for all direct care staff. *(See attached Today and Tomorrow Overview)*

  - New Point System
  - New Incentive Store
- Implementation of Second Step, skill-based, curriculum across RTC. Second Step is designed to reduce acting-out behaviors by increasing the effectiveness of the resident's interpersonal skills, including:
  - Anger Management
  - Empathy
  - Problem Solving

  A Second Step trainer will demonstrate and train on Second Step groups the week of 9/26/05. Tawnya Mock will attend Second Step train-the-trainer session in Seattle 11/05. *(See attached Second Step Overview)*
- Implementation of shift mapping form, detailing individual and group resident dynamics and how these are to be addressed, staff assignments and adjustments to the daily schedule. Copies of these are distributed to MHAs coming on shift, nursing staff, Clinical Director, and Morning Meeting team. Adolescent implementation began 8/18/05; children's implementation 8/22/05. *(See attached Shift Mapping Form)*
- Effective 9/1/05 meetings with direct care staff are being held to obtain feedback about questions, problems and issues with implementation of new programs.
- Currently recruiting a licensed Recreational Therapist or experience Activity Services Coordinator to supervise and work with Activity Services staff to provide more recreational activities that can be used as incentives for Level achievements and prosocial behaviors. A second Activity Services Associate will then be added.
- Provide training sessions with MHAs in basic skills for doing group sessions (followed up by a mentoring program), interacting with residents, and de-escalating residents who become emotionally escalated.
  - Group Skills training sessions at 1:45 and 3:15 p.m. 9/20 and 9/22/05 by Steve Heinz, PhD
  - Basic Behavior Modification Skills training sessions at 1:45 and 3:15 p.m. 10/4 and 10/6/05 by David Damschen, LCSW, Vice President of Clinical Services
- Quality Assurance Committee meets monthly to review Adverse Patient Outcomes (APO), identify trends and formulate action plans for correction. These include ESS/ESIs, incidents of aggression and injuries.
- Three Assistant Program Lead positions in place: one for Adolescent Girls, one for Adolescent Boys and one for Children's Program. These positions were created and filled to work on the units along side MHA staff, primarily on weekends and evening shifts.
- A training meeting was held with APLs and Nursing Supervisors/Charge Nurses to clarify expectations for supervision, role-modeling and coaching of MHA staff.
- Therapists, physician, nursing and education staff are routinely attending treatment planning meetings. Because of scheduling constraints, MHA staff are typically unable to attend – but their input is communicated by the staff who do attend and much of the behavioral data reported is derived from milieu points/levels and MHA medical records charting.
- Precautions meetings are held five times weekly and are attended by therapist and nursing staff to review status of residents on any sort of precautions/ restrictions.

- Weekly team meetings are held for each program attended by therapists and program leads to review residents' behaviors and therapy issues.
- Revised daily schedules
- Increased activities for all children and will add Activity Services staff (position posted)

Adolescents:
- Effective 8/19/05 hygiene breaks were changed. Residents go to the lounge instead of to their rooms; one resident at a time is using the bathroom.
- Division of adolescent team schedule with more appropriate timeframe and outline of group topics was done 8/26/05.

Children:
- School started 8/24/05; assessment of program schedule was done 8/27/05.
- Schedule changes were implemented 9/2/05.

Recommendations # 3, 4 and 10

KBH had reviewed the definitions and mandatory reporting requirements. We are changing our policies to directly reflect Montana Code and federal regulations. Incidents will be reported per the requirements. It should be noted that previously KBH reported incidents according to the rating on our severity scale (*see attached Severity Rating Scale*), which is also under revision and which we believe met the definitions of reporting requirements. Additionally, KBH will be sending a letter to MAP, BOV and State Licensing requesting a joint meeting with us to review the reporting requirements and provide clarification of requirements. It has always been KBH's intent to fulfill the requirements of the law.

Recommendation #5

It was not the intent of KBH to create a seclusion in its implementation of the previous Loss of Opportunity Policy and Procedure. More than a month prior to receipt of the draft MAP report, on 7/27/05 KBH discontinued the use of Loss of Opportunity and implemented its Special Intervention: Intensive Focus Policy and Procedure (*see attached*). Nurses training occurred on 7/19/05 and all clinical staff received the policy and procedure on 7/22/05. Health Information Management will audit resident charts to ensure appropriate documentation is occurring specific to continued access to treatment, therapy and education. If an Emergency Safety Situation or Emergency Safety Intervention (ESS/ESI) occurs while a resident is on Intensive Focus, KBH will follow our policy and procedure on seclusion and/or restraint.

Recommendation #6

We have examined and continue to examine the use of male staff to restrain female residents. Our Seclusion and Restraint Policy does address that staff are aware of and sensitive to the fact that restraint and seclusion used with residents who have pre-existing medical or physical condition(s) or with residents with a history of sexual or physical abuse are at greater risks.

Recommendation #7

The following training is outlined in our Seclusion and Restraint policy (*see attached Seclusion and Restraint Policy)*:

A. Training on this policy for all direct-care staff members will occur according to the following schedules:

1. At the time of initiation of the policy.
2. After any procedural revisions of the policy.
3. During the Orientation Process for newly hired direct-care employees.
4. Annually.

B. Appropriate procedural training for all direct care staff members in regards to this policy consists of the following:

1. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations – semi-annually.
2. The use of non-physical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations – semi-annually.
3. The safe use of personal restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion – semi-annually.
4. Mandt System: *Putting People First* with emphasis on de-escalation techniques – annually.
5. Cardio-Pulmonary Resuscitation (CPR) – annually.

Additional Direct Care Training

- Implementation of Dialectical Behavioral Therapy (DBT) program on Girls Adolescent Program 5/31/05 (training ongoing).
- Meetings were held with direct care staff to train them in program changes, answer questions, address issues. Meet with residents in each Program to explain new program.
- Development of new Emergency Medications Policy and Seclusion and Restraint Policy 9/9/05. Both policies are in implementation process *(see attached Emergency Medications and Seclusion and Restraint Policies).*
- A consultant from a sister facility will be at the facility 9/12-9/16/05 to train and model improved child and adolescent supervision techniques and to review and make additional modifications to unit daily schedules.
- Ken Robinson, PhD will conduct Moral Recognition Therapy (MRT) training for 12-15 staff 12/6-12/9/05. MRT is a 12-step behavior program that will be implemented on the boys program following the training.

Ongoing Staff Development Plan:

- Development of quarterly on-going staff development training schedule to ensure each MHA receives a minimum of one hour per month specific milieu and/or clinical intervention training. The Clinical Team will determine the training topics, Human Resources will schedule and coordinate the trainings. October, November and December training calendar to be completed by 9/23/05.
- KBH Clinical Quality Assurance Leadership Committee (CQALT), a collection of professional staff from all KBH facilities offers several training curriculum available for use at KIDS of Montana. *(See attached CQALT Training Schedule)*

Recommendation #8

The Mandt Best Practices statement (*attached*), in paragraph three Mandt states: "At the present time, there are no standards on what is or is not acceptable practice, let alone "Best Practices" for the use of physical restraint." KBH has modified our Seclusion and Restraint Policy, page 8, VI, A. As soon as the resident can contract (agree) to be safe and assessed as no longer a danger to him/herself, the Emergency Safety Intervention is discontinued. We believe that MAP's interpretation of the Mandt Best Practices Statement is mistaken. The statement does not provide that 5 minutes is the maximum time a restraint may be used. It provides in the alternative that the restraint should be authorized until the need for protection is over OR up to a maximum time of 5 minutes. It does not state "whichever is less." This statement means that a restraint may continue until the need for protection is over notwithstanding that it may be longer than 5 minutes, however, if the need for protection is over within 5 minutes then the restraint is not authorized for longer than 5 minutes. Additionally, KBH's treatment goal is to reduce physical holds to the least amount of time necessary. In order to achieve this, stimuli that has created a conflict will be immediately removed from the area and we will at that time attempt to release the child from the personal hold. It is important to emphasize that KBH's primary focus is to protect the rights of residents and to ensure that care and treatment is provided in a safe and secure setting. Therefore, restraint and seclusion are used only in an Emergency Safety Situation when there is an imminent risk of a resident physically harming him/herself or others, including staff members. Non-physical interventions are the first choice as an intervention unless safety issues demand an immediate physical response.

Recommendation #9

In the KBH Seclusion and Restraint Policy (*attached)*, Performance Improvement addresses the duration, evaluation and debriefing of each episode.

Kids Behavioral Health of Montana
Staffing Grid Modification

		Existing Staffing Grid	New Staffing Grid
Adolescent Boys Unit			
	Day Shift	1:7	1:5.5
	Evening Shift	1:7	1:5
	Overnight Shift	1:12 (facility)	1:12 (facility)
Adolescent Girls Unit			
	Day Shift	1:7	1:5.5
	Evening Shift	1:7	1:5
	Overnight Shift	1:12 (facility)	1:12 (facility)
Childrens Unit			
	Day Shift	1:5	1:4.5
	Evening Shift	1:5	1:4.5
	Overnight Shift	1:12 (facility)	1:12 (facility)
Note: Staffing Ratio for Overnight Shift will continue to be calculated on a facility census basis, not by unit.			

Kids Behavioral Health Of Montana

August 29, 2005 – September 10, 2005 ORIENTATION AGENDA

DAY 1: MONDAY General Orientation – August 29, 2005

8:00- 9:30 **Debbie Svaldi, Human Resource Manager**
Policies, Procedures, & Paperwork
1. Orientation Checklist Review
2. New Hire Paperwork
3. Job Descriptions
4. Employee Handbook /Human Resource Policies

9:30- 9:45 **Dan Leary, Corporate Payroll**
1. Payroll Policies and Procedures
2. Overrides, Overtime and Shift differentials
3. How to badge in and out
4. Payroll Periods
5. PTO and School holidays
6. Direct Deposits

9:45-10:00 **Karen Kovacich and Carol Ann Smith – Special Committees**
1. Patient Care Fund (Karen Kovacich, Chair, Patient Care Fund)
2. SIP Committee (Carol Ann Smith, Executive Assistant)

10:00-10:10 **Judy Kramer, Dietary Services**
Cafeteria Protocol
1. Staff guidelines and behaviors
2. Resident Rules

10:10-10:20 **Break (10 Minutes)**

10:20 – 11:00 **Dr. Steve Heinz, Clinical Director**
General Overview of Kids Behavioral Health Clinical Services

11:00- 11:45 **Lana Schaffer, Director of Nursing**
1. **Infection Control & Bloodborne Pathogens Review & Post Test**
2. Review Universal Precautions
3. **Germinology Review & Post Test**

11:45- 12:15 **Debbie Svaldi, Human Resource Manager**
(Take Orientees to LUNCH in the cafeteria)

12:15-1:15 **Lana Schaffer, Director of Nursing**
1. **Performance Improvement / Review & Score Post Test**
2. Risk Management / Incident Reports
3. MAP-Master Achievement Program Overview
4. ORYX Overview

1:15-2:15 **Russ Larson, Safety Officer**

Hospital Security & Safety Procedures / Review & Score Post Test

1. Security-Distribution of Employee Keys
2. Safety-Each employee's responsibility
3. HAZMAT PPE Universal & Location
4. MSDS – Description & Location
5. Emergency Preparedness Plan / Emergency School
    a. Internal/External
    b. Flip Charts
6. Life Safety
    a. Building, equipment, grounds & maintenance
    b. Maintain a safe environment for patients & staff
    c. RACE & PASS
7. Utilities & Medical Equipment
8. Smoking Policy
9. Ergonomics'-Back Safety / Proper Lifting
10. Transportation Policy

2:15 – 2:25 **Break (10 minutes)**

2:25 – 3:10 **Russ Larson, Safety Officer**

11. TOUR – Physical Environment
12. **Fire Safety Post Test**

3:10 – 3:20 **Pick Leeper, Lead Receptionist**

1. Review List of Extensions
2. How to Page
3. Calls on Hold / Transferring Calls
4. Patient ID Numbers and Phone List
5. DO NOT RELEASE PHONE NUMBERS

3:20 – 3:40 **Laura Roseboom, Care Manager and Debbie Svaldi, Human Resource Manager**

1. Labor Management Committee Presentation

3:40 – 4:30 **Debbie Svaldi, Human Resource Manager**

1. HIPAA
2. ID Badges
3. Administer TB and Hepatitis B Inoculation

4:30 **Adjourn**

DAY 2 and Day 3: TUESDAY & WEDNESDAY MANDT TRAINING – August 30 and August 31, 2005

8:00 – 4:00 **Monday--Gary Robbins, Intervention Specialist, Certified MANDT Instructor**

8:00 – 2:30 **Tuesday-- Gary Robbins, Intervention Specialist, Certified MANDT Instructor**

1. **MANDT Training / Review & Score Post Test**

CLINICAL ORIENTATION MANUALS TO BE PROVIDED

9:00 - 10:30 Russ Larson, Resident Advocate

1. **Ethics & Confidentiality / Review & Score Post Test**
2. Rights / Ethical issues in Resident/Client Care & Employee Code of Ethics & Managing Ethical Concerns Policies with **Signature Page**
3. Review Policy on Employee Relationship with Clients
4. **Resident/Client Rights / Review & Score Post Test**
5. Resident/Client & Family Complaints & Grievances Policy
   Reporting Abuse & Neglect

10:30 – 10:40 Break (10 minutes)

10:40 – 11:10 Kris Matteucci, Health Information Management Director

1. **Documentation & Charting / Review & Score Post Test**
   a. Obtain Charting Signatures
   b. Chart Audit / Chart Format Review
2. Charting Responsibilities for Direct Care Staff
   a. Therapeutic Log
3. Medical Records Confidentiality

11:10 – 11:40 Tawnya Mock, Director of Admissions

1. Admissions, Referrals, & Inquiry Calls

11:40 – 12:10 Anne Dodge, Principal

(Lunch Session in Library)

1. Introduction of Education
2. MHA expectations in the classroom
3. Classroom disruption issues

12:10 – 2:30 Steve Heinz, Clinical Director, and Russ Larson, Safety Officer--Maintaining Resident Safety

Steve Heinz 12:10 to 1:10

1. Suicide Precautions Procedures
2. Elopement Precautions Procedures
3. 15 Minute Checks Monitoring Procedures—15 Minute Locator Sheets
4. **Review and Score Post Test: Precautions**

Steve Heinz 1:10 to 1:30

5. Recognizing Resident's Suicide Potential
6. Vulnerable Times and Situations
   Understanding Non-Suicidal Self-Harming Behaviors & How to Respond

Russ Larson 1:30 to 2:30

7. Staffs' Responsibility for Constant Line-of-Sight Supervision
8. Maintaining a Safe, Contraband-Free Environment

2:30 – 2:45 Break (15 minutes)

2:45 – 4:15 Jane Griffith, Children's Program Lead

Overview of Children's Program

1. Prompting System
2. Program Rules

4:15 **Adjourn**

DAY 5: FRIDAY Clinical Orientation Unit Experience– September 2, 2005

7:00 – 2:00 **Jane Griffith, Children's Program Lead**
Children's Unit—mentoring with assigned staff

2:00 – 3:00 **Jane Griffith, Children's Program Lead**
1. Discuss Children's Unit Experience
2. Children's Program Instruction

Review & Score Clinical Orientation Children Post Test

DAY 6 : TUESDAY Clinical Orientation – September 6, 2005

8:30 – 9:30 **Claudia Bennington LCPC, Therapist**
1. **Culturally Diverse Residents / Review & Score Post Test**
2. Native American Values Cultural Awareness

9:30 – 9:45 **Break (15 minutes)**

9:45 – 11:15 **Dr. Steve Heinz, Clinical Director**
1. **Normal Growth & Development / Review & Score Post**

11:15 – 11:45 **Jane Griffith, Children's Program Lead**
(Take Orientees to LUNCH in the cafeteria)

11:45 – 12:45 **Dr. Ann Spillan, Medical Director**
1. Role of Medication & Treatment
2. Basic Medications
3. Classes of Medications
4. Side Effects
5. PRN Medications
6. Signs & Symptoms

12:45 – 2:45 **Dr. Steve Heinz, Clinical Director**
1. Understanding Residents' Psychiatric Diagnosis
2. **Diagnosis / Review & Score Post Test**
3. **Treatment Planning / Review & Score Post Test**
   a. The Treatment Plan Format
   b. The Treatment Plan Process
   c. Charting to the Treatment Plan

2:45 – 3:00 **Break (15 minutes)**

3:00 – 5:00 **Benetta Rodacker, Unit Coordinator**
1. Discuss Adolescent Unit Experience
2. Prompting System

3. Program Rules
4. Role Plays
5. Afternoon Shift Schedule
6. Virtues Project Overview
7. DBT

5:00 **Adjourn**

DAY 7 : WEDNESDAY Clinical Orientation Unit Experience– September 7, 2005

7:30 -2:00 **Benetta Rodacker, Unit Coordinator**
Adolescent Unit—mentoring with assigned staff

2:00-3:00 **Benetta Rodacker, Unit Coordinator**
1. Discuss Adolescent Unit Experience
2. Adolescent Program Instruction
3. **Review & Score Clinical Orientation Adolescent Post Test**
Resident Monitoring / Review & Score Post Test

DAY 8: THURSDAY Clinical Orientation – September 8, 2005

9:30 – 11:00 **Dr. Steve Heinz, Clinical Director**
1. **Restraint & Seclusion Training and Post Test**
2. How to fill out ESI form

11:00 – 11:30 **Orientees go to LUNCH in the cafeteria**

11:30 – 1:30 **Dr. Steve Heinz, Clinical Director and Assistant Program Leads**
1. Skills for Managing Escalated Emotions and Behaviors

1:30 – 2:15 **Pana Schafer, Therapist**
1. Working with Low Functioning Residents
2. **Post Test Managing Difficult Behaviors**

2:15 – 2:45 **Pam Broughton, CEO**
1. KBH, Inc. Overview
2. KBH of Montana Overview
3. HERO Campaign

2:45 – 3:00 **Break (15 minutes)**

3:00 – 4:00 **Dr. Steve Heinz, Clinical Director**
1. Maintaining Boundaries with Residents
2. **Boundaries Post Test**

4:00 – 5:00 **Benetta Rodacker, Unit Coordinator, Adolescent Program Lead**
1. How to effectively run MHA groups
2. What materials are used, where they are located
Second Step

5:00 **Adjourn**

DAY 9: FRIDAY CPR and FIRST AID – September 9, 2005

7:30 – 5:00 Lana Schaffer Director of Nursing, Certified CPR/First Aid Instructor

1. CPR and First Aid Training / Review & Score Post Test

ALL DOCUMENTS MUST BE COMPLETELY SIGNED BY THE EMPLOYEE AND THE SUPERVISOR FOR ORIENTATION COMPLIANCE AND EVIDENCE OF COMPLETION.

DAY 10: SATURDAY, Clinical Orientation Unit Experience – September 10, 2005

8:30 – 3:00 or 3:00 – 9:30 Orientees will be assigned to additional unit experience.

KIDS Behavioral Health of Montana

AOC Checklist

AOC Name: _____

Date: _____ Time: _____

		Yes	No
1.	Shift Mapping Form available to all staff?		
2.	Are groups being done as scheduled?		
	Length of time as scheduled?		
3.	Are staff interacting with residents?		
4.	Is staff placement/positioning appropriate?		
5.	Are residents engaged in activity? What activity?		
6.	Are precautions being followed for residents on precautions/ intensive focus?		
7.	Is the facility/RTC clean and orderly?		

Today Tomorrow Program (T 'n' T)
Overview

By David Damschen

T 'n' T employs a Positive Behavior Support Methodology designed to deter and extinguish anti-social behavior by shaping, supporting, and encouraging pro-social behavior. T 'n' T is designed to provide compelling reinforcement for targeted behaviors and creates an objective measurement mechanism that reduces staff prejudices. It also establishes a longitudinal data record that can be evaluated in a single system design format or can be utilized for program efficacy studies.

Key Concepts

Reinforcement – T 'n' T utilizes two types of reinforcement; standardized and individualized. Standardized reinforcements are the same for all residents and provide increasing freedom and independence as rewards for demonstrated ability to be responsible and manage personal behaviors. These rewards include such things as later bed times, access to special outings, and independent study time in school work on personal projects.

Standardized rewards are secondarily reinforced by a token system, usually in the form of a student store, through which residents can convert accumulated T 'n' T points into material objects such as books, bathroom supplies, toys, etc.

Individualized rewards are designed by the resident in conjunction with staff in a Multi-disciplinary Team meeting (MDT) and are unique to that individual resident. These might include one-to-one time with the animal therapist, early out from school, special one-on-one outing, quality time with staff, etc.

The reinforcements must be applied with unerring consistency. Student store hours should be posted and residents must have scheduled access during these hours. Also follow through on individualized reinforcers must be religiously consistent. Rewards must occur within short time frames, i.e. points are given throughout the day, new levels are awarded daily, individual rewards must occur within a one week time frame and student store access should occur multiple times per week.

Point Sheets

Point sheets are designed in MDT meetings. The resident should be included in the design and modification of all his or her point sheets.

The level system is based on a 5 point scale. Levels 1 through 4 are achieved by earning points as follows:

- 85% and above equals level 4
- 75 – 84% equals level 3
- 65 – 74% equals level 2
- Below 65% equals level 1

The highest level, Independence, is achieved by consistently maintaining a high level demonstrating responsible behavior that would be acceptable in a community setting. The MDT team, including the resident, determines that the point sheet is no longer required and grants "independent status". If during independent status, behaviors deteriorate, the T 'n' T program is re-administered.

T 'n' T point sheets are designed to award points incrementally throughout the day providing continuous behavioral feedback to the resident. Once a point is earned, it cannot be taken away. The points a resident earns today results in their level status the following day. If a resident has a major blow up at the end of the day but has earned sufficient points to be a high level the following day, he or she will still be awarded that level. All residents have the opportunity to earn their level daily regardless of historical behaviors. A resident is never "frozen", "buried", "locked" for days or weeks at a time.

The level system is designed to be non-punitive but has natural consequences built into the programming. The natural consequences are normal phenomena based on level such as earlier bed time, limits to access to off site outings, etc.

The residents group performance with regard to level acquisition should form a bell curve with as many residents on the highest level as on the lowest level and the largest number of residents in the middle. If a bell curve is not achieved, the point sheets are either too difficult or not challenging enough.

Any client that persistently fails to achieve level requires special attention. One or more of the following issues is the problem:

- Reinforcers are inadequate
- The T 'n' T points sheet is too difficult
- The T 'n' T program is poorly implemented

Implementation

During implementation of the T 'n' T program, some staff will have a tendency to distort the program into a consequence based approach. Successful implementation requires strong surveillance by management staff to hold staff accountable for utilizing the proper approach.

2nd Step Overview

By David Damschen

2nd Step is a skill based curriculum designed to reduce acting out behavior by increasing the effectiveness of the residents interpersonal skills. 2nd Step teaches the following general skill sets:

- Impulse control
- Anger management
- Empathy
- Pro-social problem solving

Successful implementation of the 2nd Step curriculum requires a systemic approach. All staff, including managers, teachers, therapists, front line workers must have proficiency in the curriculum and must be aware of the focus of the week.

Short informal meetings and written postings help keep staff and residents focused on the weekly curriculum design.

The role plays and activities in the 2nd Step groups should be spontaneously reinforced by all staff during all shifts using the teachable moment technique.

Longitudinal studies indicate that when successfully implemented, 2nd Step alone will cut acting out behaviors in half the first year.

Consistent managerial surveillance and accountability is required for successful implementation. Some staff may have a tendency to rush through material in a rote way. Strong supervision and consistent training is required to help staff perform in a meaningful and impactful way.

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: Severity Rating Scale for Accident/Injury Reports		**PAGE 1 of 1**	
FUNCTIONAL AREA: Environment of Care; Provision of Care, Treatment and Services		**REFERENCES: EC; PC**	
EFFECTIVE DATE: 11/20/02		**APPROVED BY: Executive Committee, MSEC, Governing Board**	
REVIEWED/REVISED: 1/26/05	**REVIEWED/REVISED:**	**REVIEWED/REVISED:**	**REVIEWED/REVISED:**

PURPOSE:
To establish a severity scale for injuries that occurs as a result of accidents, assaults, or self-harm. The severity scale will be used to determine if the injury is reportable to outside agencies.

PROCEDURE:
1. All injuries that occur must be documented through the KIDS Behavioral Health of Montana (KBH) Incident Report policy and procedure. The Incident Report has a section to rate the severity of each injury. The scale below will be used to rate severity of injuries.

   0 = No injury

   1 = Extremely minor injury. No treatment required.

   2 = Minor injury. Minor treatment required provided for by the facility staff.

   3 = Moderate injury. Treatment may be provided by facility staff but may require precautionary treatment outside of the facility.

   4 = Serious injury. Not a true medical emergency. Requires medical evaluation/treatment outside the facility. This rating does not include "rule outs" but only actual injuries requiring professional treatment. This includes injuries requiring sutures, actual fractures, minor outpatient surgery and similar level of care.

   5 = Critical injury. Any injury that requires emergency transportation (via ambulance) and/or medical care requiring overnight hospitalization.

   6 = Death

2. All injuries require an Incident Report. Severity ratings of 4 – 6 require outside reporting.

3. The Risk Manger in conjunction with the Safety Officer will determine if an incident with a severity rating of 4 – 6 requires referral to the Quality Assurance Committee who will ensure outside reporting takes place.

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: **Special Program: Intensive Focus**		**PAGE 1 of 2**	
FUNCTIONAL AREA: **Provision of Care, Treatment and Services**		**REFERENCES:** **PC 4.20**	
EFFECTIVE DATE: 10/23/01		**APPROVED BY: Executive Committee, MSEC, Governing Board**	
REVIEWED/REVISED: 11/20/02	REVIEWED/REVISED: 4/30/03	REVIEWED/REVISED: 12/29/04	REVIEWED/REVISED: 1/26/05
REVIEWED/REVISED: *Draft 6/6/05*	REVIEWED/REVISED: 6/29/05	REVIEWED/REVISED:	REVIEWED/REVISED:

POLICY

Intensive Focus is a special program that is utilized with residents who are engaging in repetitive patterns of behavior that is seriously disruptive to the treatment milieu and/or their own progress. It is to be used as a temporary measure to have residents become redirected toward their treatment goals. It may be used with individual residents or with a resident team, as a group. To be able to return to normal milieu activities is the goal of the Intensive Focus special program. Although the Intensive Focus special program may entail a period of physical separation from other residents, it is not intended as a Seclusion (i.e., an Emergency Safety Intervention). An assigned staff person is to be physically present with the resident(s), and the resident's unauthorized leaving of the area designated for the special program will not be physically prevented unless the resident's behavior constitutes an Emergency Safety Situation.

PROCEDURE

The Intensive Focus protocol is initiated by the Program Lead (or the Nursing Supervisor if the Program Lead is unavailable). Thereafter, the need to continue the protocol will be evaluated by the Program Lead (or the Nursing Supervisor if the Program Lead is unavailable) daily. When individual residents are placed on Intensive Focus and are thereby separated from their resident team, additional MHA staff may be required to supervise them.

1. Expectations of the Resident

   a. Cooperate with all program rules and instructions by assigned staff.
   b. Work on assigned therapeutic assignments and/or assigned schoolwork.
   c. Initially, attendance in classroom, group, recreation, or social activities with the resident Team will be restricted. A resident may attend and participate in specific groups and activities at the discretion of the Program Lead. Otherwise, interactions with other residents must be with prior permission from assigned staff. Permission for interactions and participation with other residents will be dependent on

compliance with the special program protocol and progress toward goals set for the Intensive Focus period.

d. Meals will be eaten separate from other residents.
e. Participation in physical exercise/activity will be offered each day.

2. Expectations of staff assigned to monitor residents on Intensive Focus

a. Assist resident to learn and cooperate with expectations of the Intensive Focus protocol.
b. Meet basic needs of resident while maintaining safety.
c. Provide interaction with the resident as specified in the "Instructions to Assigned Staff" section of the Intensive Focus Program form. Otherwise, interactions with the resident(s) should be limited, primarily focused on maintaining safety and encouraging the resident(s) to complete assignments.
d. Be alert to resident attempts at manipulation to subvert the Intensive Focus protocol into special time and attention that would be counter-therapeutically reinforcing.
e. Utilize the Intensive Focus Assessment Card to assess the resident's behaviors while on Intensive Focus.
f. Provide detailed medical records documentation in of the resident's behaviors while on Intensive Focus.

3. Expectations for the Program Lead and Therapist

a. Work with direct care staff to provide age/developmentally appropriate therapy assignments.
b. See the resident daily during workweek, providing an opportunity to review and process therapeutic assignments.
c. Collaborate with other Treatment Team members to assess the need to continue the Intensive Focus Protocol.

4. Transitioning back to the normal milieu activities

a. The resident's cooperation and compliance in completing therapeutic assignments, achievement of Satisfactory scores on the Intensive Focus Assessment Card, and identification and discussion of the behaviors that resulted in their being placed on Intensive Focus will determine their readiness to reinstitute participation in the regular program.
b. Transitioning back to the normal milieu activities may begin when the resident shows evidence of being able to cooperate and comply in completing therapeutic assignments and school work, follow instructions, behave non-disruptively and express willingness to redirect themselves in a positive say towards their treatment goals. The transitioning process will include brief or time-limited periods of having the resident(s) reengage in normal milieu activities and alternate back to Intensive Focus until the Treatment Team is convinced the resident no longer needs the intensive structure of Intensive Focus.

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: **Seclusion and Restraint**		**PAGE 1 of 15**	
FUNCTIONAL AREA: **Provision of Care, Treatment and Services**		**REFERENCES: PC 4.40, PC 10, PC 12**	
EFFECTIVE DATE: 6/1/01		**APPROVED BY: Executive Committee, MSEC, Governing Board**	
REVIEWED/REVISED: **9/18/01**	**REVIEWED/REVISED:** **11/28/01**	**REVIEWED/REVISED:** **2/27/02**	**REVIEWED/REVISED:** **5/22/02**
REVIEWED/REVISED **11/20/02**	**REVIEWED/REVISED** **2/26/03**	**REVIEWED/REVISED** **5/26/04**	**REVIEWED/REVISED** ***Draft 4/1/05***
REVIEWED/REVISED **4/27/05**	**REVIEWED/REVISED** ***Draft 9/9/05***	**REVIEWED/REVISED** *Draft 9/21/05*	**REVIEWED/REVISED**

POLICY STATEMENT:

KIDS Behavioral Health (KBH) of Montana's primary focus is to protect the rights of residents and to ensure that care and treatment are provided in a safe and secure setting. Therefore, restraint and seclusion are used only in an Emergency Safety Situation when there is an imminent risk of a resident physically harming him/herself or others, including staff members. Non-physical interventions are the first choice as an intervention unless safety issues demand an immediate physical response.

The use of Restraint and Seclusion poses an inherent risk to the physical safety and psychological well being, loss of dignity, and violation of resident rights. Thus KBH of Montana emphasizes its commitment to continually explore ways to prevent, reduce and strive to eliminate the use of Restraint and Seclusion use through effective Performance Improvement initiatives. KBH of Montana is committed to the following principles:

- A major focus of Continuous Process Improvement is the prevention and reduction of the use of Restraint and Seclusion.
- It is leadership's role at KBH to create an environment that minimizes the incidents that give rise to Restraint and Seclusion use.
- Emphasis is placed on the prevention of emergencies that have the potential to lead to the use of Restraint and Seclusion.
- Providing effective alternative behavioral management approaches.
- The preservation of resident's safety and dignity when Restraint and Seclusion are used.
- That staff are aware of and sensitive to the fact that Restraint or Seclusion used with residents who have pre-existing medical or physical condition(s) or with residents with a history of sexual or physical abuse are at greater risk.
- That the role of the family/guardian is important in decisions and activities that are related to the use of Restraint and Seclusion.

- That the resident has the right to be free from Restraints and Seclusion of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff.
- That as a mental health agency, treatment is provided to residents with severe mental illnesses who are, at times, dangerous to themselves or others and that the use of Restraint and Seclusion may be necessary to prevent injury or death.

Additionally, because the use of seclusion and restraint poses an inherent risk to the physical safety and psychological well being of residents and staff, these extremely restrictive measures are only used in emergencies when:

- a resident's behavior presents an imminent risk of physical harm to him/herself or others, including staff.
- less restrictive measures have been tried but have failed to ensure the safety in the milieu.
- safety issues demand an immediate physical response.

When it becomes necessary to seclude or restrain a resident, every attempt will be made to maintain the resident's right to dignity, respect, privacy and safety. KBH prohibits the use of seclusion or restraint for any other purpose, such as discipline, coercion, convenience, or retaliation.

Whenever possible two staff members must be present at the scene prior to putting "hands on" any resident. The two staff members are identified as 1) the staff member directly supervising the resident and 2) the nurse that the staff member has solicited for assistance. Assistance may also be solicited from other specified members of the clinical team. In Emergency Safety Situations, another mental health associate (MHA) may be solicited for assistance by the supervising staff member. This decision will be reviewed for determination of legitimacy and subject to disciplinary action if determined that the supervising staff member could have, but failed to, call for a nurse or other specified clinical team staff for assistance.

If a resident sustains an injury during a seclusion and/or restraint procedure, the resident will be immediately assessed by a nurse, and then further evaluated by the medical physician for assessment of "serious injury." In the absence of the medical physician, the Medical Director will assess the injuries of the resident and document her/his assessment in the resident's chart. All resident injuries will be reviewed for adherence to this Policy and Procedure and proper Mandt procedures, and appropriate disciplinary action will be initiated for any substantiated violations.

PROCEDURE

I. DEFINITIONS:

A. **Abuse** – The willful infliction or injury, unreasonable confinement, intimidation or punishment, with resulting physical harm, pain or mental anguish. This includes staff neglect or indifference to inflection of injury or intimidation of one resident by another. Abuse includes such acts as:

- The rape, sexual assault, or sexual exploitation of a resident.
- The striking of a resident.
- The use of excessive force when placing a resident in personal restraint.
- The use of bodily or chemical restraints on a resident, which is not in compliance with federal and state laws and regulations; and
- Threats, coercion or restrictive actions intended to influence the treatment decisions of a resident.

B. **Emergency Safety Intervention (ESI):** The use of restraint, seclusion or medication as an immediate response to an Emergency Safety Situation.

C. **Emergency Safety Situation (ESS):** A situation in which it is immediately necessary to restraint, seclude or administer an emergency medication to a resident to prevent imminent:

- Probable death or substantial physical harm to the resident because the resident overtly or continually is threatening or attempting to commit suicide or serious bodily harm; or
- Physical harm to others because of threats, attempts, or other acts the resident overtly or continually makes or commits, and preventive de-escalation, or verbal techniques have proven ineffective in defusing for injury. These situations may include serious incidences of shoving or grabbing others over their objections. Where the behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the resident, other residents, staff and others. These situations do not include verbal threats or verbal attacks.

D. **Accompanying:** The re-direction or guidance of a resident who does not physically resist moving with the staff member and situation does not escalate into a need to physically force the resident to move. The term *accompanying* may include the temporary touching of holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a resident who is acting out to walk to a safe location.

E. **Physical Re-direction** – Use of physical force by a staff member to move or direct a resident to another location. Escorting is a type of personal restraint. Physical re-direction does not include accompanying a resident.

F. **Imminent Significant Risk** - Risk that is immediate. Given the situation, a

prudent person must be able to conclude that bodily harm will occur to either the resident or to another person if there is no immediate intervention. Imminent significant risk does included the probability of imminent harm resulting from a resident running away.

G. **Mechanical Restraint:** Any device attached or adjacent to the resident's body that s/he cannot easily remove that restricts freedom of movement or normal access to his or her body. The use of mechanical restraint is prohibited at KBH of Montana.

H. **Personal Restraint:** The application of physical force, including Escorting, without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding the resident without undue force in order to calm or comfort him or her, or holding a resident's hand or arm to safely escort a resident from one area to another.

J. **Seclusion**: The involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

K. **Serious Injury**: Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

L. **Time Out/Quiet Time:** A procedure in which the resident , on the resident's own initiative, cooperatively enters and remains in a designated area for a period of time. (Time Out, and similar interventions intended to be preventive are not appropriate in emergency situations.) The resident may terminate self-initiated use of Time Out at any time. A self-directed may not be enforced under any circumstances.

N. **Emergency Medication** – The resident receives a P.R.N. medication used to regain emotional/behavioral control that is on the Medication Administration Record and Master Treatment Plan. The resident is not overly sedated and can rejoin the milieu and participate in their treatment. (See Emergency Medication Policy)

O. Chemical Restraint – The use of any chemical including pharmaceuticals, through topical application, oral administration, injection, or other means, solely for the purpose of immobilizing, sedating or restraining a resident as a mechanism of control and is not a standard treatment for the resident's medical or psychiatric condition. The use of chemical restraint is prohibited at KBH of Montana.

J. **Other Licensed Practitioner:** Registered and Licensed Practical Nurses (licensed in the State of Montana), trained in the use of Emergency Safety

Interventions, and authorized by KBH to conduct a face-to-face assessment of the physical and psychological well being of residents.

II. ADMISSION

A. During the admission process the resident's parent(s) or legal guardian(s) are given information about the KBH's policy regarding the use of seclusion and restraint during an Emergency Safety Situation that may occur while the resident is at KBH. The restraint and seclusion policy will be communicated in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, KBH will provide interpreters or translators.

B. The signed consent form will document that information about the use of seclusion and restraint has been provided. An acknowledgment in writing will be obtained from the resident's parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an Emergency Safety Situation. This acknowledgment will be filed in the resident's record.

C. A copy of the facility policy will be provided to the resident and to the resident's parent(s) or legal guardian(s). The complete copy of the policy will be provided if requested.

D. KBH will provide the resident's parent(s) or legal guardian(s) with the phone number and address of the State Protection and Advocacy organization.

•Montana Advocacy Program
400 North Park Ave., Second Floor
P.O. Box 1681
Helena, MT 59620
Telephone: (406) 449-2344 (Voice/TTD)

III. PLAN OF CARE

A. An initial assessment shall be performed for the resident's plan of care, during which information is obtained by the nurse, physician and therapist that could help minimize the Emergency Safety Interventions, including information that would place the resident at greater risk during an Emergency Safety Intervention, such as:

1. Any pre-existing medical conditions.
2. Physical limitations or disabilities.
3. History of dangerous behaviors while in seclusion.
4. History of sexual or physical abuse.

B. KBH prohibits the use of PRN (as needed) or standing orders for Emergency Safety Interventions.

C. The KBH Treatment Team will review each resident's admission information as to a history of aggressive impulses and behavior. When a resident has had occurrences of discrete episodes of failure to resist aggressive impulses that may result in serious assaultive acts toward self or others, the treatment team will identify this in the resident's Treatment Plan as a "Problem." Specified interventions and goals will be determined by the Treatment Team and addressed in the resident's Treatment Plan. The Treatment Plan may include the use of seclusion and/or restraint interventions.

- A Treatment Plan for aggressive behaviors will also be developed by the Treatment Team for any resident who has had no previous pre-admission history of aggressive behaviors but who demonstrates aggression after admission that compromises the safety of the resident or others.

D. A resident's treatment plan may include specific measures that should be incorporated in the event that Emergency Safety Interventions necessary, e.g., specification of the gender of staff monitor, instructions to notify the family or guardian, etc.

IV. IMPLEMENTING SECLUSION

A. Non-physical interventions are the first choice interventions unless safety issues demand an immediate physical response. When a resident's behavior presents an imminent risk to him/herself or others and less restrictive measures (e.g., verbal redirection, de-escalation attempts, reduction of stimuli, a time out, etc.) have been tried without success, the resident will be assessed for the need to seclude.

B. If the resident is not being physically held, enough trained staff to safely intervene will be assembled. The designated leader will verbally direct the resident and attempt to de-escalate the situation. If this does not work, the staff will intervene at the direction of the leader and use only enough force to safely contain the resident and escort him/her to the seclusion area.

C. In emergency situations, a nurse may initiate a seclusion procedure followed immediately by a call to the physician to report the circumstances and obtain a written or verbal order. The date and time of this consultation is documented in the resident's medical record. All physicians' orders shall comply with Section VII of this policy.

D. At the implementation of seclusion, potentially dangerous items are removed from the room and the resident (e.g., shoes, pencils, pens, jewelry), which requires searching the resident's pockets and clothing using the guidelines in the *Search Policy*.

E. The nurse will inform the resident of the reason for the seclusion and describe the criteria for discontinuing the intervention, e.g., "You have been secluded because you have tried repeatedly to assault your roommate. When you can contract (agree) to be safe, you can come out of the room."

F. The nurse will assign a trained Mental Health Associate or Unit Clerk to visually monitor the resident as provided in Section IX. *Monitoring Restraint and Seclusion* of this policy.

G. In the rare event of a lengthy seclusion, bathroom and fluids are offered hourly or as needed, and meals/snacks are offered at scheduled times unless this is contraindicated by the resident's documented clinical status. In this case, the regular meal or snack will be offered as soon as possible. These intervals clearly present opportunities to evaluate readiness for the intervention to be discontinued.

H. Locked seclusion may be contraindicated if:

1. The resident is claustrophobic or otherwise extremely fearful of being locked in a room alone.
2. The resident has a history of abuse/neglect in which he/she was locked alone in a room.
3. The use of locked seclusion increases the resident's level of agitation.
4. The resident is on Suicide Precautions.
5. The resident has a history of inflicting self-harm during seclusion or becomes a danger to self during seclusion.

V. IMPLEMENTING PERSONAL RESTRAINT

A. When a resident's behavior presents an imminent risk to him/herself or others and less restrictive measures (e.g., verbal redirection, de-escalation attempts, reduction of stimuli, time out, seclusion, etc.) have been tried without success, the resident will be assessed for the need to be restrained. KBH-Montana only utilizes Personal/Physical Restraint.

1. The staff member who is interacting with the resident and observing the behavior of the resident will request assistance from one of the nursing staff.
2. The nursing staff member will:

   a. Consult with the staff member.
   b. Assess the situation.
   c. Determine the necessity for physical intervention with the resident in order to protect the safety of the resident or others.

d. If an Emergency Safety Intervention is deemed necessary to assure the safety of the resident or others, the intervention will be initiated by the nurse subject to a physician's order as provided in Section XII of this policy.

e. The nurse will assume the role of leader of the Emergency Safety Intervention and will monitor the following parameters:

1) Procedure according to policies and procedures.
2) Physical and psychological status of the resident.
3) Cessation of the procedure or other appropriate actions to provide safety for the resident and/or others.

3. Exceptions that allow for immediate intervention with out pre-approval by a nurse or nurse initiation of physical restraint include, but are not limited to, the following examples:

a. Physical altercation between two peers.
b. Physical attack by a resident of a staff member.
c. Life threatening self-abusive behaviors.
d. Life threatening injuries.

VI. DISCONTINUING AN EMERGENCY SAFETY INTERVENTION

A. As soon as the resident can contract (agree) to be safe and assessed as no longer a danger to him/herself or others, the Emergency Safety Intervention is discontinued.

B. The nurse will determine, direct and communicate the plan for release to the resident and staff.

C. The resident will have an opportunity to process the procedure with all trained staff persons who were involved in the Emergency Safety Intervention. At this time, staff and resident will:

1. Attempt to assure the resident's understanding of why the restraint was necessary.
2. Describe the behavioral expectations for reintegration into the community.
3. Discuss circumstances:

a. Leading up to the seclusion/restraint procedure.
b. Opportunities for making different choices.
c. Identify anger tools.
d. Identify other coping strategies.

VII. ORDERS FOR RESTRAINT OR SECLUSION.

A. Orders for restraint or seclusion must be by a physician.

B. If the resident's treatment team physician is available, only he or she can order restraint or seclusion. If the resident's treatment team physician is unavailable, the physician covering for the treatment team physician can order restraint or seclusion.

C. A physician must order the least restrictive Emergency Safety Intervention that is most likely to be effective in resolving the Emergency Safety Situation based on consultation with staff.

D. If the order for restraint or seclusion is verbal, the verbal order must be received by a nurse while the Emergency Safety Intervention is being initiated by staff or immediately after the Emergency Safety Situation ends. The physician must verify the verbal order in a signed written form in the resident's record. The physician must be available to staff for consultation, at least by telephone, throughout the period of the Emergency Safety Intervention.

E. Each order for restraint or seclusion must:

1. Be limited to no longer than the duration of the Emergency Safety Situation.
2. Under no circumstances exceed the following time frames according to age:

    a. 4 hours for residents ages 18 to 21.
    b. 2 hours for residents ages 9 to 17.
    c. 1 hour for residents under age 9.

F. Each order for restraint or seclusion must include:

1. The name of the ordering physician.
2. The date and time the order was obtained.
3. The Emergency Safety Intervention ordered, including the length of time for which the physician authorized its use.

G. A physician who orders the use of restraint or seclusion must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The physician ordering the use of restraint or seclusion must:

1. Consult with the resident's treatment team physician as soon as possible and inform the team physician of the Emergency Safety Situation that required the resident to be restrained or placed in seclusion.
2. Document in the resident's record the date and time the team physician was consulted.

H. The physician must sign the restraint or seclusion order in the resident's record as soon as possible and within the time frame of KBH's policy.

VIII. ASSESSMENT AND DOCUMENTATION

A. Nursing staff are responsible for performing an initial and every 15 minutes thereafter assessment of a client in restraint or seclusion to include the following:

1. Signs of any injury associated with applying restraint or seclusion.
2. Nutrition and hydration.
3. Circulation and range of motion in the extremities.
4. Vital signs.
5. Hygiene and elimination.
6. Physical and psychological status and comfort.
7. Readiness for discontinuation of restraint or seclusion.

B. Within 1 hour of the initiation of the Emergency Safety Intervention a physician, or other licensed practitioner* trained in the use of Emergency Safety Interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to:

1. The resident's physical and psychological status.
2. The resident's behavior.
3. The appropriateness of the intervention measures.
4. Any complications resulting from the intervention.

C. Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

1. Each order for restraint or seclusion.
2. The time the Emergency Safety Intervention actually began and ended.
3. The time and results of the 1-hour assessment
4. The Emergency Safety Situation that required the resident to be restrained or put in seclusion.
5. The name(s) of staff involved in the Emergency Safety Intervention.

C. KBH will maintain a record of each Emergency Safety Situation, the interventions used, and their outcomes.

IX. MONITORING RESTRAINT AND SECLUSION.

A. RESTRAINT

1. Clinical staff trained in the use of Emergency Safety Interventions must be physically present, continually assessing and monitoring the physical and psychological well being of the resident and the safe use of restraint throughout the duration of the Emergency Safety Intervention. This staff will document specific resident behaviors every 5 minutes for the first fifteen minutes and then every 15 minutes on the *Seclusion and Restraint Report Form.*
2. If the Emergency Safety Situation continues beyond the time limit of the order for the use of restraint, a registered nurse must immediately contact the ordering physician to receive further instructions.
3. A physician, or other licensed practitioner *permitted by the state and the facility to evaluate the resident's well-being and trained in the use of Emergency Safety Interventions, must evaluate the resident's well-being immediately after the restraint is removed.

B. SECLUSION

1. Clinical staff, trained in the use of Emergency Safety Interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well being of the resident in seclusion.
2. A room used for seclusion must:
   a. Allow staff full view of the resident in all areas of the room.
   b. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.
3. If the Emergency Safety Situation continues beyond the time limit of the order for the use of seclusion, a nurse must immediately contact the ordering physician to receive further instructions.
4. A physician, or other licensed practitioner* permitted by the state and the facility to evaluate the resident's well-being and trained in the use of Emergency Safety Interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

X. NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN(S).

A. KBH will notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each Emergency Safety Intervention.

B. Staff must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the Emergency Safety Intervention, including the date and time of notification and the name of the staff person providing the notification.

C. Each unsuccessful attempt to notify the parent(s) or legal guardian(s) or disconnected phone numbers will be documented as well as any messages left for the parent(s) or legal guardian(s) to contact KBH.

XI. POST-INTERVENTION ASSESSMENT

A. DEBRIEFING I

1. Within 24 hours after the use of restraint or seclusion, staff involved in an Emergency Safety Intervention and the resident must have a face-to-face discussion.
2. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident.
3. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility.
4. The facility will conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s).
5. The discussion will provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

B. DEBRIEFING II

1. Within 24 hours after the use of restraint or seclusion, all staff involved in the Emergency Safety Intervention, and appropriate supervisory and administrative staff, will conduct a debriefing session,

2. The debriefing will include a that includes, at a minimum, a review and discussion of:

    a. The Emergency Safety Situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention.
    b. Alternative techniques that might have prevented the use of the restraint or seclusion.
    c. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

C. INITIATION/FACILITATION/DOCUMENTATION OF DEBRIEFING I/II

1. The Clinical Director or his designee (i.e. Charge Nurse, Team Lead) is responsible for the following:
   a. Initiating Debriefing I/II.
   b. Facilitating Debriefing I/ II.
   c. Soliciting the signature of the resident or documenting that the resident declined/refused to sign.
   d. Documenting the Debriefing process.
   e. Collection and analysis of data for Performance Improvement.

2. Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

XII. MEDICAL TREATMENT FOR INJURIES

A. Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an Emergency Safety Intervention.

B. Staff must document in the resident's record, all injuries that occur as a result of an Emergency Safety Intervention, including injuries to staff resulting from that intervention.

C. Staff involved in an Emergency Safety Intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

XIII. REPORTING OF SERIOUS OCCURRENCES

A. The facility will report each serious occurrence to the Montana Department of Public Health and Human Services, Montana Licensing and Credentialing Department Division of Public Health and Human Services, Montana Advocacy Program, and Board of Visitors. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in this policy, and a resident's suicide attempt. This report must be made by no later than close of business the next business day after a serious occurrence. The report may be made by telephone or facsimile transmission. The report must include the following information:

1. Name of the resident involved in the serious occurrence.
2. A description of the occurrence.
3. The name, street address, and telephone number of the facility.

B. Staff will notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence. The notification may be made by telephone.

C. Staff will document in the resident's record that the serious occurrence was reported to the agencies listed in XIII.A. including the name of the person to whom the incident was reported. A copy of the report must be maintained in the incident and accident report logs kept by KBH of Montana.

D. In addition to the reporting requirements contained in paragraph XII.A. of this policy, a death of any resident must be reported to the Centers for Medicare and Medicaid Services (CMS) regional office in Denver, which report must be made no later than close of business the next business day after the resident's death. The report may be made by telephone. Staff must document in the resident's record that the death was reported to the CMS regional office.

E. If the occurrence is a sentinel event under JCAHO guidelines, voluntary reporting to JCAHO will be determined by the Quality Assurance Committee. Refer to KBH's Policy and Procedure for *Sentinel Event.*

XIV. APPLICATION OF TIME OUT

A. Time out is not seclusion, however, a resident in time out must never be physically prevented from leaving the time out area. If the resident is physically prevented from leaving the area of time-out, then the time out is seclusion and all requirements of this policy related to seclusion must be complied with.

B. Time out may take place away from the area of activity or from other residents (exclusionary), or in the area of activity or other residents (inclusionary).

C. Staff must monitor the resident while s/he is in time out.

XV. NOTIFICATION OF CLINICAL/ADMINISTRATIVE LEADERSHIP OF KBH

A. A member of clinical management (appropriate Team Lead, Nurse Lead, Director of Social Services, Director of Nursing) shall be notified of extended or multiple episodes of restraint or seclusion.

1. This information is presented, reviewed, and discussed daily Monday through Friday in Morning Meetings that are attended by clinical and administrative leaders of KBH.
2. Weekend occurrences of restraint or seclusion are reviewed during the Monday Morning Meeting following the weekend.

B. Multiple ESS/ESI episodes are defined as:
   - Two or more separate episodes in a 12 hour period
   - Greater than three episodes of restraint or seclusion within a seven-day period.

C. Clinical Leadership must be notified within 24 hours

D. When multiple or extended episodes of seclusion or restraint are identified for a resident, a Special Treatment Team Staffing is held and appropriate modifications and recommendations are made to the Treatment Plan.

XVI. TRAINING

A. Training on this policy for all direct-care staff members will occur according to the following schedules:

   1. At the time of initiation of the policy.
   2. After any procedural revisions of the policy.
   3. During the Orientation Process for newly hired direct-care employees.
   4. Annually.

B. Appropriate procedural training for all direct care staff members in regards to this policy consists of the following:

   1. Techniques to identify staff and resident behaviors, events, and environmental factors that my trigger emergency safety situations – semi-annually.
   2. The use of non-physical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations – semi-annually.
   3. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion – semi-annually.
   4. Mandt System: *Putting People First* with emphasis on de-escalation techniques – annually.
   5. Cardio-Pulmonary Resuscitation (CPR) – annually.

C. Nurses will receive additional training and are required to pass competency criteria on the *One-Hour Assessment.*

D. Training attendance and competency testing will be recorded in the personnel files of appropriate direct-care staff members.

XVII. PERFORMANCE IMPROVEMENT

A. Individual Case Evaluations

1. All residents' treatment plan interventions are reviewed on both an *as needed* basis when special circumstances warrant, i.e., occurrence of multiple episodes of ESS/ESI as defined in XV.B.1, 2, and on a regular monthly (28 day) schedule.
2. Special Staffings for a resident may be initiated by any member of the Clinical, Administrative Leadership Team or Treatment Team of KBH after a resident has had multiple ESS/ESI episodes.
3. The resident's treatment plan reviews cover in part:

    a. The frequency patterns, and effectiveness of specific behavior interventions.
    b. Strategies to reduce the need for behavior interventions overall.
    c. Specific strategies to reduce the need for use of seclusion or restraint when appropriate.

B. KBH collects data and performs internal audits on restraint and seclusion to:

1. Ascertain that restraint and seclusion are used only as Emergency Safety Interventions (ESI).
2. Data on all restraint and seclusion episodes are collected monthly from and classified for the facility as a whole and by unit/program by the following:
    - Shift
    - Staff who initiated the process
    - The length of each episode
    - Average length of time
    - Date of each episode
    - Time each episode was initiated
    - Day of the week each episode was initiated
    - Type of restraint used
    - Injuries to residents
    - Injuries to staff
    - Age of the resident
    - Gender of the resident
    - Debriefing data
    - Multiple instances of restraint or seclusion experienced by resident within a 12-hour time frame
    - The number of episodes per resident
    - Use of emergency medications
3. Identify opportunities for incrementally decreasing the numbers of occurrences of seclusion and restraints, reducing the length of time of

seclusions/restraints and improving safety to residents and staff during restraint and seclusion use.

C. Data from the ESS/ESI Reports is collected on a daily basis and a monthly report is prepared by the Clinical Director. Monthly statistics are forwarded to the Risk Manager to be entered on the APO Report. Referrals are made immediately to the KBH Resident Advocate and appropriate supervisory staff when indicated.

1. Data statistics include, but are not limited to all data documented on the ESS/ESI Report Form.
2. Data statistics are reported by the Clinical Director to:

    a. KBH Corporate's Risk Management Department monthly.
    b. Executive Committee quarterly.
    c. Governing Board quarterly.

KIDS BEHAVIORAL HEALTH OF MONTANA, INC.

POLICY AND PROCEDURE

POLICY AND PROCEDURE: **Emergency Medications**		**PAGE 1 of 5**	
FUNCTIONAL AREA: **Provision of Care, Treatment and Services; Medication Management**		**REFERENCES: HCFA HR 4365; PC.12.10, PC.12.20, PC.12.40, PC.12.50, PC.12.70, PC.12.110; MM.3.10, MM.3.20, MM.4.10, MM.6.10**	
EFFECTIVE DATE: ***Draft 8/18/05***		**APPROVED BY: Executive Committee, MSEC, Governing Board**	
REVIEWED/REVISED: ***Draft 9/9/05***	**REVIEWED/REVISED:**	**REVIEWED/REVISED:**	**REVIEWED/REVISED:**

POLICY:

KIDS Behavioral Health's (KBH's) primary focus is to protect the rights of residents and to ensure that care and treatment are provided in a safe and secure setting. Therefore, Emergency Medications are used to assist the resident to regain emotional/behavioral control or when there is imminent risk of a resident physically harming himself or herself, or others, including staff members. Non-physical and non-pharmacological interventions must be the first choice as an intervention, unless safety issues demand an immediate physical response. The nurse in charge must sign off as reviewing interventions prior to any intramuscular pharmacological medication being given.

The use of pharmacological interventions **poses an inherent risk** to the physical safety and psychological well being, loss of dignity, and violation of resident rights. Thus KBH emphasizes its commitment to continually explore ways to prevent, reduce, and strive to eliminate the use of pharmacological intervention use through effective Performance Improvement initiatives.

This standard may vary according to individual state or licensure requirements.

I. VOLUNTARY USE OF EMERGENCY MEDICATION BY RESIDENT or PRN

Emergency Medication refers to the procedure in which a resident receives a PRN medication used to regain emotional/behavioral control that is on the Medication Administration Record and Master Treatment Plan and maintains the resident's ability to participate therapeutically in the milieu.

II. EMERGENCY MEDICATION USED IN CONJUNCTION WITH PHYSICAL RESTRAINT

Clinical justification for the use of an Emergency Medication refers to the procedure in which a resident receives a PRN medication used to regain emotional/behavioral control that is on the Medication Administration Record and Master Treatment Plan when the resident is in a Physical Restraint and when there is imminent risk of a resident physically harming himself or herself, or

others, including staff members. Non-physical interventions must be the first choice as an intervention, unless safety issues demand an immediate physical response.

PROCEDURE:

1. Criteria for Voluntary use of an Emergency Medication
   a. The resident has received a psychological/psychiatric evaluation on admission and aggressive/assaultive behaviors have been identified and have been listed as a problem with measurable objective goals and interventions on the Master Treatment Plan. Or these behaviors may be manifested after admission and added as a problem to the Master Treatment Plan.
   b. The resident on admission has identified behavioral triggers and self-calming interventions on the De-escalation preference form.
   c. The attending physician/L.I.P has written an order for a PRN medication that includes:
      1) Specific reason for the medication (i.e., agitation, aggressive behavior, uncontrollable rage, assault on others, self-injurious behavior, etc.)
      2) Dosage
      3) Route (i.e., By Mouth or Intramuscular)
      4) Time interval (i.e., every four hours)

2. Before dispensing, a pharmacist or physician reviews all medication orders except in urgent situations when the resulting delay would harm the resident. In the event the pharmacist is not in the facility or available by telephone, they will review all orders as soon as possible (i.e. the following morning).
   a. The Pharmacist will review all medication orders for the following:
      1) The appropriateness of the drug, dose, frequency and route of administration
      2) Therapeutic duplication
      3) Real or potential allergies or sensitivities
      4) Real or potential interactions between the order medication and other medications, food and laboratory values.
      5) Other contraindications
      6) Variation from normal criteria for use
      7) Other relevant medical-related issues or concerns
   b. All concerns, issues, or questions are clarified with the individual prescriber before dispensing the medication.
   c. The staff nurse enters the medication on the Medication Administration Record and the resident's Master Treatment Plan at the time of the order.
   d. All PRN medications will be reviewed monthly during the Master Treatment Plan review by the clinical team for the number of times it has been utilized during the month and assess the appropriateness of its continued use. Based on these findings, the medication may be renewed for continued use, the resident's routine medication regime may be adjusted to decrease the need for the PRN medication, or the medication may be discontinued if it is deemed not to be necessary.

3. Notification of need for Emergency Medication

a. The resident may self-report that they are feeling restless, anxious, aggressive, agitated, combative or out of control.
   1) The resident may request of the nurse that a medication be given to them to assist them in regaining emotional/behavioral control.
   2) After assessing the resident, observing the resident for "trigger behaviors" that they disclosed on admission (I.e. pacing, stiff posture, yelling/swearing, etc.) and after suggesting de-escalating techniques the resident has listed as their personal preferences, the nurse may administer the PRN medication if the professional judgment of the nurse it is warranted (i.e. not demonstrating drug seeking behaviors).
      a) **At KBH of Montana, the nurse must contact the physician/nurse specialist before administering the medication for review of behaviors and approval to administer the PRN medication**
      b) The nurse will encourage the resident to take the medication orally if more than one route is ordered.
   3) The Mental Health Associate or Nurse might observe the resident demonstrating "trigger behaviors" that they disclosed on admission. The Mental Health Associate /Nurse will make the resident aware of their behaviors and suggest de-escalating techniques; including using a PRN medication if the resident is in agreement, before they lose emotional/behavioral control.
      a) **At KBH of Montana, the nurse must contact the physician/nurse specialist before administering the medication for review of behaviors and approval to administer the PRN medication**

   4) The nurse will monitor the resident for efficacy and side-effects after 30 minutes and 90 minutes and document the resident's response and any adverse reactions.

4. Initiating an Emergency Medication with the resident in a Physical Restraint
   a. Whenever possible, the nurse will offer the resident non-physical and non-pharmacological interventions as the first choice of intervention if the resident can contract to remain safe.
   b. The nurse will determine and document when there is imminent risk of a resident physically harming himself or herself, or others, including staff members.
   c. **At KBH of Montana, the nurse must contact the physician/nurse specialist before administering the medication for review of behaviors and approval to administer the PRN medication**
   d. The nurse will first offer the resident the Emergency Medication orally. If the resident is in agreement, the medication will be given orally.
   e. If the resident does not agree to take the medication by mouth and continues to demonstrate unsafe behavior, necessitating a continuation of the physical restraint and will not contract to be safe, the nurse may give the medication intramuscularly (if ordered) to reduce the time of the physical restraint and the risks inherent with prolonged restraint.
   f. The nurse will document the rationale, indication for the medication and the site used.

g. The nurse will suggest to the resident that they lie down and rest while allowing the medication to take effect. The resident should be allowed to rest until they feel calm and regain emotional/behavioral control before rejoining the milieu.
h. The nurse will monitor the resident for efficacy and side-effects after 30 minutes and 90 minutes and document the resident's response and any adverse reactions.

5. Monitoring of Intramuscular Medications and Process Improvement
   a. The Treatment Center's Clinical Leadership must review each intramuscular utilization to ensure appropriate non-physical/non-pharmacological interventions were utilized first.
   b. If non-physical/non-pharmacological interventions were not utilized first, staff involved must be educated through training and documented on the Human Resource Educational Disciplinary Counseling Form.
   c. If it is noted that the same staff continues the use of intramuscular medications without non-physical interventions, disciplinary action, including possible termination will begin.
   d. The Medical Director, Director of Clinical Operations, Director of Quality/Risk Management, Director of Nursing and/or Process Improvement Committee will review all uses of Intramuscular Emergency Medications and investigate unusual or possible unwarranted patterns of utilization. They will also continually explore ways to prevent, reduce, and strive to eliminate the use of pharmacological interventions.
      1) The following statistics/data will be reviewed monthly;
         a) Total number of incidents of Intramuscular Emergency Medications facility-wide and the Rate of Occurrence monthly.
         b) Total number of incidents of Intramuscular Emergency Medications occurring on each unit monthly.
         c) The day of the week and the time of the day each incident of Intramuscular Emergency Medication occurs to identify patterns and trends.
         d) Number of incidents of Intramuscular Emergency Medications given monthly by resident.
         e) Number of Intramuscular Emergency Medications given monthly by individual nurse.
         f) Use of Intramuscular Emergency Medications when contraindications are present.
      2) The following guidelines will be considered to be indicative that a problem may exist in the utilization of Intramuscular Emergency Medications:
         a) Continuously increasing trends of utilizing Emergency Medications; especially when they exceed the Mean for three consecutive months or exceed the Upper Control Limit in any given month.
         b) Any use of Intramuscular Emergency Medications with a resident in which possible contraindications exists.
         c) Two or more incidents of Intramuscular Emergency Medications involving the same resident in any 8-hour period.
         d) Three or more incidents of Intramuscular Emergency Medications involving the same resident in a seven day period. (This will trigger a Special Treatment Plan review by the Clinical Team).

e) Any incident of Intramuscular Emergency Medication resulting in an injury to the resident and/or tissue/muscle injury sustained from repeated injections in the same area.

CQALT Trainings Currently Available

4 or 8 hours – Bruised Brains and Bad Behavior – The Tragedy of Fetal Alcohol Syndrome by: David Damschen and Derek McKenzie

20 + hours – Dialectical Behavioral Therapy by: David Damschen and Vicki Belluomini

1 hour – Asperger's Disorder – An Introduction by: Melissa Aubrey-Harper

1 hour – Asperger's Disorder – Treatment Protocols by: Melissa Aubrey-Harper

1 hour – Service Gaps by: Gary Jones

1 hour – Cornerstone Principles of Leadership by: David Damschen

1 hour – Temptations of Leadership by: David Damschen

1 hour – Professional Communication by: David Damschen

1 hour – The Essential Elements of Teamwork by: David Damschen and Derek McKenzie

1 hour – Leading for the Long Haul by: David Damschen

2 hours – Suicide Prevention by: Larry Larcade

1 hour – I Don't Know Why I Act This Way – Oppositional/Conduct Disorder by: David Damschen

1 hour – Treatment Planning: The In's and Out's by: Kim Miller

1 hour – Post Traumatic Stress Disorder by: David Damschen

1 hour – DSM IV by: David Damschen

1 hour –Counter Transference in The Milieu – How To Use It, How To Avoid Being Used By It by: Emily Barber

1 hour - Reactive Attachment Disorder – And It's Manifestation in Adolescents by: Dr. Steve Heinz, Clinical Director – KBH of Montana

Training Currently in Research and Development

1 hour – Eating Disorders, The Nursing Perspective by: Lana Schaffer

1 hour – Female Sexual Offender vs Sexual Reactivity by: Rita Fowler & Linda Carlson

1 hour – Impact On Children Who Witness Domestic Violence by: Emily Barber

1 hour – Elements of Group Therapy by: David Damschen

1 hour – Train The Trainer Training by: BJ Barkley

Trainings in Conceptual Stage

1 hour – Normal Adolescent Sexuality by: Lissa Montgomery

1 hour – Train The Interactive Trainer Training by: David Damschen, if I have to...

1 hour – Borderline Personality Disorder by: David Damschen

BEST PRACTICES
DAVID MANDT AND ASSOCIATES

At times, the behavior of individuals served may pose a threat of harm to self or others, in spite of the best efforts of all involved to use positive, non-aversive intervention strategies. When this happens, physical interaction may be needed to protect people from harm.

We agree with TASH, TheArcLink, and others that restraint has no programmatic or therapeutic value. **There is nothing positive, other than the provision of safety, about restraint**. The use of restraint, seclusion and other invasive/aversive interventions represents treatment failure, not treatment. The failure is at a systemic and not a personal level. Unless the intervention was abusive or neglectful, staff use restraint in the context of the training they received from the organization.

At the present time, there are no standards on what is or is not acceptable practice, let alone "Best Practice" for the use of physical restraint. Physical restraint is not positive except that it may prevent harm or injury. However, it can also cause trauma, physical as well as emotional or psychological. Restraint can cause death, especially restraints that take place on the floor.

A Positive Behavior Interventions and Support approach must address the issue of (1) whether or not to authorize the use of physical restraint, and, if so, what precipitating factors may call for the use of physical restraint; and (2) what techniques should not be used in physical restraint (on the floor, hyperextending joints, causing pain, etc.)

We believe that there may be times when physical interaction is needed to protect an individual from harming themselves and/or others. When physical interaction with others is needed to restrict or limit an individual's behavior, the specific skills must:

- Be used only after non-physical interaction has proven ineffective in maintaining the safety of all persons
- Maintain the normal range of motion for the individual (no hyperextension of joints) and minimize bruising, injury, or pain by specific design
- Used for a recommended maximum of one minute, with a five minute maximum time in manual restraint
- Authorized after the person empowered to authorize the use of a restraint and/or seclusion technique has experienced its' use.
- Only be used to protect people from seriously harming themselves and/or others.
- Authorized for use only until the need for protection is over or up to a maximum time of 5 minutes

David Mandt and Associates further believes that:

- "Taking people down" for purposes of a floor restraint is prohibited
- Floor restraints are only appropriate if used as a transition from the floor to a standing or sitting position when the individual has fallen to the floor.
- Physical restraint has no place in a behavior support plan (not to used as a response to non-compliance or task avoidance behavior)
- The use of hyperextension of joints, pain compliance, pressure points and pain, hitting, pinching, slapping, and other forms of physical abuse are prohibited.
- David Mandt and Associates will work with any and all organizations on a collaborative basis to find ways to minimize, if not eliminate, the need for and use of physical restraint.
- After each use of restraint, the team, including the individual served and/or their legal guardian, must participate in processing what events led up to the use of restraint, and what can be done in similar circumstances in the future so restraint is not needed.